Aldine ISD Voluntary Student Accident Plans

AT SCHOOL COVERAGE **Plan A $ 64.00** **Plan B $ 50.00**
Voluntary Grades PK-12
(a) while on the School premises: during the hours and on the days School is in regular session, and during the hours and on the days when School is not in session while the Insured Person is participating in or attending any Sponsored and Supervised School Activity (excluding Senior High school interscholastic football); and
(b) while away from the School premises: other than traveling, if participating in a Sponsored and Supervised School Activity (excluding Senior High school interscholastic football); and
(c) while traveling directly to or from the Insured Person's residence and School: for regular School sessions, or for any Sponsored and Supervised School Activity in School designated vehicle (excluding Senior High school interscholastic football).

24 HOUR COVERAGE **Plan A $ 231.00** **Plan B $ 176.00**
Voluntary Grades PK-12
Coverage is in force for each person for whom the 24-Hour Coverage premium has been paid as set forth in the Policy on a twenty-four (24) hour per day basis (excluding Senior High school interscholastic football).

MEDICAL PAYMENTS
The policy provides Full Excess Medical Expense benefits for loss due to a Covered Injury up to the Total Maximum for all Accident Medical Benefits of $25,000 for each Covered Accident. Medical treatment must be provided by a qualified, licensed physician and must begin within 90 days from the date of the Covered Accident.

Benefits will be payable for Covered Medical Expenses incurred within 104 weeks from the date of the Covered Accident up to the maximum Benefit Amount per service as shown on the Schedule of Benefits of the Policy. Artificial limbs, artificial eyes or other prosthetic appliances are covered expenses.

Full Excess Medical Expense means the Company will pay the Medically Necessary Covered Expenses after the Insured Person satisfies any Deductible; and only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides. The Company will pay benefits without regard to any Coordination of Benefits provision in such Other Health Care Plan.

Schedule of Benefits for Voluntary Student Accident Plans

These benefits are paid up to the following maximums, not to exceed $25,000 for each injury once the $100 corridor deductible has been met.

COVERED EXPENSES	Plan A	Plan B
In-Patient Hospital Services	90% of URC Charges	70% of URC Charges
Hospital Miscellaneous Expenses	90% of URC Charges	70% of URC Charges
Nurse Services	90% of URC Charges	70% of URC Charges
Orthopedic Appliances Outpatient	90% of URC Charges	70% of URC Charges
Emergency Room Treatment	90% of URC Charges up to $2,000 per Covered Injury	70% of URC Charges up to $2,000 per Covered Injury
Surgical Facility	90% of URC Charges up to $2,000 per Covered Injury	70% of URC Charges up to $2,000 per Covered Injury
Primary Surgeon	90% of URC Charges	70% of URC Charges
Assistant Surgeon	35% of Surgeon's Allowance	35% of Surgeon's Allowance
Anesthesia	35% of Surgeon's Allowance	35% of Surgeon's Allowance
In-Hospital Doctor's Visits	90% of URC Charges	70% of URC Charges
Doctor's Office Visits	90% of URC Charges	70% of URC Charges
Out Patient X-Ray	90% of URC Charges	70% of URC Charges
Out Patient CT Scan, MRI	90% of URC Charges	70% of URC Charges
Out Patient Laboratory Tests	90% of URC Charges	70% of URC Charges
Out Patient Physiotherapy	90% of URC Charges up to $50 per visit up to a maximum of 5 visits	70% of URC Charges up to $50 per visit up to a maximum of 5 visits
Ambulance Services	90% of URC Charges not to exceed $800	70% of URC Charges not to exceed $800
Medical Equipment Rental	90% of URC Charges	70% of URC Charges
Dental Services	90% of URC Charges not to exceed $500	70% of URC Charges not to exceed $500
Prescription Drugs (Out Patient)	90% of URC Charges	70% of URC Charges
Heart and Circulatory Benefit	90% of URC Charges	70% of URC Charges
Eyeglasses, Contact Lenses, Hearing Aids	90% of URC Charges	70% of URC Charges

This insurance provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plan. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act

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ENROLL ONLINE FOR QUICKER SERVICE or COMPLETE AND MAIL

⇨ ______________________ ____ ______________________ ___/___/______
Student's First Name **M** **Last Name** **Birth Date**

⇨ ____ ______-______-________
Address **City** **ST** **Zip** **Phone**

⇨ **Aldine ISD** ______________________ ______
Name of School **Grade**

Plan A School Time Coverage ☐ $ 64.00	Plan A 24 Hour Coverage ☐ $231.00	Plan B School Time Coverage ☐ $ 50.00	Plan B 24 Hour Coverage ☐ $176.00

Complete for ☐ **MASTERCARD** ☐ **VISA** **Name on Card, Last** ______________________ **First**______________________

Card Number______________________ **Expiration Date Mo**__________ **Year**__________

Cardholder Signature______________________ **Date**______________

Aldine ISD Voluntary Student Accident Plan

Exclusions

1. Normal health checkups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
   (a) Employed or retained by the Certificateholder; or
   (b) Who is the Covered Person or a member of his immediate family;
4. Charges which:
   (a) The Covered Person would not have to pay if he did not have insurance; or
   (b) Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   (a) An aircraft, except as a fare-paying passenger;
   (b) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   (c) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
   (a) A snowmobile;
   (b) Any two or three wheeled motor vehicle;
   (c) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
   (a) The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
   (b) Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food, unless a Sickness Expense Rider is inforce under this Certificate ;
11. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;
12. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Certificate;
13. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
14. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
15. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
16. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
17. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore; unless provided for in this Certificate;
18. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
19. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
20. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
21. Any loss which is covered by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
22. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
23. Rest cures or custodial care;
24. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
25. Expenses incurred for an Accident or Sickness after the Benefit Period shown in the Schedule of Benefits;
26. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;
27. Services and supplies furnished by the Policyholder's infirmary, its employees, or doctors who work for the Policyholder ;
28. Any bacterial infection that was not caused by an Accidental cut or wound.

Accidental Death & Dismemberment Benefits (Within 180 Days)

Benefit	Amount
Loss of Life…	$15,000
Loss of Two or More Hands or Feet	$30,000
Loss of Sight of Both Eyes	$30,000
Loss of One Hand or One Foot and Sight in One Eye	$30,000
Loss of One Hand and Foot	$30,000
Loss of Sight in One Eye	$15,000
Loss of One Hand or Foot	$15,000
Loss of Thumb and Index Finger of Either Hand	$7,500
Exposure and Disappearance	**Included**

How to File a Claim

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills. However, if you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code). If this information is not on the bill, we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.
4. Only one claim form per accident needs to be submitted. Once completed, make a photocopy for your records, and mail to: **WebTPA: P.O. Box 669 Grapevine, TX 76099-0669**

Or call 1-877-563-7492 for assistance

Enrollment Options

- Complete and detach the enrollment form.
- Make Checks or money order payable to Texas Monarch Management Corp. Do Not Send Cash. Credit card payment is also accepted.
- Clearly print name of child on the check or money order.
- Send the enrollment form and payment to:
  Monarch Management Corp.
  3201 Cherry Ridge Drive, Suite D405, San Antonio, TX 78230
- Your cancelled check, money order stub or credit card statement is your proof of purchase.
- Keep this for your reference, you will receive no policy.
- If you have questions about this coverage, please call:
  Monarch Management Corp. 1-800-662-2778.

Underwritten by: United States Fire Insurance Company

Offered by:

Enroll Online at www.mmc-ins.com