2016-2017

$1,000,000

# Student Accident Insurance

## Who is eligible

The policy is available to all enrolled students, faculty and administration of a participating school.

## Who pays the premium

Coverage is purchased by the parent or guardian of enrolled students or by individual faculty or administrative members interested in enrolling in the program.

## Coverage term

Coverage is effective when the premium is received by the school administrator or the effective date of the policy, whichever is later. Coverage expires at 12:01 a.m. of the first day of the next school year or the anniversary of the policy, whichever is earlier. Individual coverage ends when affiliation is ended with the participating school.

**Choice of two** school approved insurance plans with optional Extended Dental Benefit

## School time accident coverage

Insurance coverage for the hours and days when school is in session and while attending school-sponsored and supervised activities on or off the school premises.

**Includes:**

— Activities during school year
— Travel to and from school
— School-supervised and sponsored activities
— Class trips
— Religious services

## Full-time 24-hour accident coverage

Insurance coverage is in force around the clock.

**Includes:**

— Any covered activity, regardless of location
— 24-hour-a-day coverage, including summer
— Weekends and vacation periods
— Protection at home or while away

### PLAN ADMINISTRATOR

**ISI New England**
**305 Carteret Street**
**Beaufort, SC 29902**

### CLAIMS ADMINISTRATOR

**Health Special Risk, Inc.**
**4100 Medical Parkway**
**Carrollton, TX 75007**

Coverage becomes effective on the earliest of the following: (1) the first day of school, if signed enrollment form and premium are received before the seventh school day, or (2) the date enrollment form and premium are received by the school administrator.

SPEC-1032 (5-16); QHSR-MA-24-FB

# Accident Insurance Protection

Providing a maximum of $1,000,000 Accident Medical Expense

## Full Excess Coverage

Provides for payment of Usual and Customary (U&C) expenses Incurred for treatment of an injury caused by a covered accident, subject to the maximums stated in the policy. Covered expenses must be for appropriate treatment and the first expense must be incurred within 90 days following the covered accident. Benefits are payable for covered expenses that are not recoverable from another Health Care Plan. If the insured is not covered by another Health Care Plan, benefits are payable like primary coverage. To be payable, expenses must be incurred within 365 days after the covered accident. All benefits will be based on the normal charge, in the absence of insurance, made by the provider for any appropriate treatment, but not more than the prevailing charge in the area for like services by a provider with similar training and experience. Where appropriate, usual and customary charges will be based on a relative value schedule appropriate to the area and the type of service provided.

## Covered expenses per covered accident

Hospital daily room & board up to ..... $500/day

Operating room not to exceed ..... U&C up to $1,500/hour

Treatment by a physician or surgeon (assistant surgeon fees are not a covered expense) not to exceed ..... U&C up to $2,000

Anesthetics including administration not to exceed ..... U&C up to $500

X-ray examinations (MRI, CAT scan, etc.), including interpretation and/or reading not to exceed ..... U&C up to $750

Full-time private duty nursing services by a registered graduate nurse (visiting nurse services are not a covered expense) ..... U&C

Physical therapy or similar treatment not to exceed ..... U&C up to $500

Treatment by a legally qualified chiropractor not to exceed ..... U&C up to $50

Prescribed orthopedic appliances, crutches or rental of medical equipment ..... U&C up to $750

Prescribed drugs and medicines for use outside the hospital ..... U&C

Home health care services ..... as required by MA insurance code section 175:110K

Ground ambulance to initial treatment facility ..... U&C

Dental services to sound, natural teeth (includes dental X-rays)* ..... U&C up to $10,000

*If there is more than one way to treat a dental problem, benefits will be paid for the least expensive procedure, provided it meets acceptable dental standards.

## Accidental death, dismemberment, or loss of sight

Provides for payments of benefits in accordance with the following table when loss results from a covered accident. Loss must result within 365 days of the accident. If more than one loss results from any one accident, only the largest amount will be paid.

| | |
|---|---|
| Loss of life | $5,000 |
| Both hands or both feet, or the sight of both eyes | $10,000 |
| One hand and one foot | $10,000 |
| One hand and the sight of one eye | $10,000 |
| One foot and the sight of one eye | $10,000 |
| One hand or one foot | $5,000 |
| The sight of one eye | $1,000 |

"Loss" means with regard to hands and feet, complete severance through or above the wrist or ankle joint; with reference to the eye, total, permanent loss of all vision that is irrecoverable by natural, surgical or artificial means. "Severance" means the complete separation and dismemberment of the part from the body.

| Coverage chosen: | Annual Premium |
|---|---|
| School Time Coverage | ❏ $10 |
| School Time with Extended Dental | ❏ $18 |
| 24-Hour Coverage | ❏ $70 |
| 24-Hour Coverage with Extended Dental | ❏ $78 |

## $50,000 maximum Extended Dental benefit

### Coverage is in effect 24 hours a day

By adding an additional premium, dental benefits may be extended to provide payment of covered expenses to a maximum of $50,000. This additional benefit provides payment for the U&C expenses incurred within two years from the date of the covered accident for treatment, repair and replacement of each injured natural tooth, including examination, diagnosis, X-ray, restorative treatment, endodontics and oral surgery, plus for the replacement of caps, crowns, dentures and orthodontic appliances.

**Limitations:** When this benefit is selected, dental services will only be covered under this benefit and not under the Accident Medical Plan. When certified by a dentist that treatment must be deferred until after the two-year benefit period, benefits will be paid to a maximum of $600 per covered accident. If there is more than one way to treat a dental problem, covered benefits will be paid for the least expensive procedure provided it meets acceptable dental standards.

All claims for deferred dental benefits must be submitted no later than 30 days after the end of the two-year benefit period.

**Claims procedure:** In case of accident, notify school immediately. Secure claim form from your school, attach bill(s) to completed claim form and mail to the address indicated on the claim form. **Claims for benefits must be filed within 90 days from date of loss, or as soon as reasonably possible.**

**Important notice:** This information is a brief description of the important features of this insurance plan. It is not a contract. Terms and conditions of coverage are set forth on policy form series BAM-03-1000.00, BAM-09-1000.00, or applicable state versions. This Blanket Accident Medical Insurance Policy is subject to the laws of the jurisdiction in which it is issued. It is not available in all states. Additional exclusions and limitations apply. The availability of this offer may change. You may review a copy of the policy upon request. **Please keep this material as a reference. An individual ID card will not be issued.**

# Full Excess Accident Medical Coverage

## Not sure which plan is right for you?

Call your school's plan administrator

**ISI New England**

**888.474.1959**

Claims administrator

**Health Special Risk, Inc.**

**866.523.3186**

"Health Care Plan" means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, blanket, franchise, family or individual insurance policies, subscriber contracts, uninsured agreements or arrangements, coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice and individual practice plans, medical benefits provided under automobile "fault" and "no-fault" – type contracts, medical benefits provided by any governmental plan or coverage or other benefit law, except a state-sponsored Medicaid plan; or a plan or law providing benefits only in excess of any private or non-governmental plan, and other valid and collectible medical or health care benefits or services.

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## Exclusions and limitations

Benefits will not be paid for injuries caused by:

(1) suicide, intentionally self-inflicted injury, or any attempt thereat while sane or insane;
(2) commission or attempt to commit a felony or an assault; or commission of or active participation in a riot or insurrection;
(3) declared or undeclared war or act of war;
(4) services or treatment provided by persons who do not normally charge for services, unless there is a legal obligation to pay;
(5) flight in, boarding or alighting from an aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
(6) travel in or on any on-road or off-road vehicle that does not require motor vehicle licensing;
(7) bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
(8) an accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless the covered person holds a valid learners permit and the covered person is receiving instruction from a driver's education instructor;
(9) services or treatment rendered by any person who is employed or retained by the policyholder or living in the covered person's household; a parent, sibling, spouse or child either of the covered person or the covered person's spouse; the covered person;
(10) cosmetic surgery, except for reconstructive surgery needed as the result of a covered injury;
(11) injuries compensable under workers' compensation law or any similar law;
(12) sickness, disease, bodily or mental illness, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound, or accidental ingestion of contaminated food;
(13) the covered person being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred or voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;
(14) any hospital stay or days of a hospital stay that are not appropriate treatment for the condition and locality;
(15) participation or practice for non-school sponsored skiing, ice hockey, lacrosse, soccer or tackle football (applicable to school time coverage only);
(16) taking part in senior high school interscholastic football, including travel to and from games and practice, unless specifically provided for in the Policy.

### After selecting the school-approved insurance plan that's best for you:

- ❑ Detach and complete the enrollment form
- ❑ Enclose a check or money order
- ❑ Do not send cash
- ❑ Return enrollment form and check or money order to:

**ISI New England Student Insurance Payment Center**
**P.O. Box 588**
**Beaufort, SC 29901-0588**

(Detach Here)

## Student Accident Insurance

2016/2017 Enrollment Form

School name: _____

District name: _____ Grade/dept: _____

Person to be insured: _____

Student accident insurance chosen for: ❑ Student ❑ Faculty ❑ Administration

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Date of Birth: _____

Social Security #: _____

Parent Signature: _____

Policy Number (company use only) _____

| Coverage chosen: | Annual Premium |
|---|---|
| School Time Coverage | ❑ $10 |
| School Time with Extended Dental | ❑ $18 |
| 24-Hour Coverage | ❑ $70 |
| 24-Hour Coverage with Extended Dental | ❑ $78 |

Date: _____ Amount enclosed: _____ (Do not send cash)

Please include check or money order payable to: **QBE Insurance Corporation**

**There is no obligation to purchase this insurance plan.**

Do you want this insurance? ❑ Yes ❑ No