We Build Futures

Neshaminy School District

Administrative Offices • 2250 Langhorne-Yardley Road • Langhorne, PA 19047

August 2022
LOW COST – HIGH LIMIT
STUDENT ACCIDENT GROUP INSURANCE

THE SCHOOL DISTRICT DOES NOT CARRY MEDICAL INSURANCE FOR STUDENTS

This is a reminder to parents with a child or children **attending** school in our School District that we do not carry medical insurance on students but do provide parents with the opportunity to select a primary excess group insurance plan for students. Student accident insurance can help you eliminate the possibility of out-of-pocket expenses, since many group insurance policies no longer pay full hospital and medical expenses and may require a deductible or co-insurance. There are three plans with the following options available for your consideration:

- **Option #1 Plan A - School Time Coverage – Costs $27 per student** – This will cover injury occurring while the student is traveling to and from school, while attending school sponsored activities such as plays, assemblies, class trips, interscholastic sports other than Sr. high football, intramural sports, gym and physical education classes, etc. **Plan AA costs $36 per student; Plan AAA costs $45 per student**

- **Option #2 Plan A - 24 Hour Coverage – Costs $98 per student** – This will cover all of the above, plus accidents occurring away from school, in the evenings and on weekends, vacations, etc. **Plan AA costs $130 per student; Plan AAA costs $165 per student**

- **Dental Accident Insurance Option Plan A – Costs $8.00** per student and **can be added to either plan** listed above. **Plan AA costs $8.50 per student; Plan AAA costs $9.00 per student**

Please note that the plans should be considered in conjunction with any other family medical insurance you may have.

Please see the Voluntary Student Accident Medical Plans for a complete description of the plans and the various coverage options. If you have any questions, please call an Insurance Broker at Alive Risk directly at (215) 946-8888 between 8:00 a.m. and 4:30 p.m.

To Enroll: Please visit https://www.aliverisk.com/StudentAccidentEnrollment to complete the enrollment form.

Enrollment opens on Wednesday, August 31, 2022.

This insurance can be purchased anytime during the 2022-2023 school year. Parents enrolling more than one child must fill out an application for each child. Your completed online order is your proof of payment. Thank you!

Sincerely,

Donald B. Irwin, Jr.
Business Administrator

DI/rtt
MI:Student InsLtr22/23

2022 – 2023 Voluntary Student Accident Medical Plans

Pennsylvania

Voluntary Plans	A	AA	AAA
Accidental Medical Maximum	$25,000	$25,000	$25,000
Deductible	$0	$0	$0
Coverage	Full Excess	Full Excess	Full Excess
Benefit Period	52 weeks	52 weeks	52 weeks
Loss Period	60 days	60 days	60 days
Condition of Coverage	School Time or 24-Hour	School Time or 24-Hour	School Time or 24-Hour
Inpatient Hospital Services			
Room & Board	$200/day	$500/day	U&C
Intensive Care	$400/day, 7 day maximum	$1,000/day, 7 day maximum	U&C
Hospital Miscellaneous Expenses			
Hospital Miscellaneous Expenses[1]	$5,000	$10,000	U&C
In-Hospital Physiotherapy	U&C, 30 visit maximum	U&C, 30 visit maximum	U&C, 30 visit maximum
In-Hospital Orthopedic Appliances	$1,000	$2,000	U&C
Outpatient Hospital Services			
Outpatient Orthopedic Appliances	$500	$1,000	U&C
Ambulatory Medical Center	U&C	U&C	U&C
Emergency Room Treatment (without Hospital Confinement)	$300	$400	U&C
Outpatient X-ray, CT Scan, MRI	$350	$650	U&C
Outpatient Laboratory Tests	$350	$650	U&C
Outpatient Physiotherapy[2]	$40/visit, 10 visit maximum	$50/visit, 10 visit maximum	U&C, 10 visit maximum
Outpatient Nursing Services	U&C	U&C	U&C
Outpatient Prescription Drugs	U&C	U&C	U&C
Physician Services			
Surgery	$1,000	$2,000	$3,000
Assistant Surgeon	25% of surgery allowance	25% of surgery allowance	25% of surgery allowance
Second Opinion or Consultation	$150	$300	U&C
Anesthesia and its Administration	25% of surgery allowance	25% of surgery allowance	25% of surgery allowance
In-Hospital Visits	U&C	U&C	U&C
Office Visits	U&C	U&C	U&C
Other			
AD&D	$10,000	$20,000	$20,000
Benefit Limit for Covered Losses from any one Motor Vehicle Accident	$10,000	$10,000	$10,000
Ambulance (Air & Ground)	U&C	U&C	U&C
Eyeglasses, Contact Lenses, Hearing Aids	U&C	U&C	U&C
Rates – School Time	**$27**	**$36**	**$45**
Rates – 24 Hour	**$98**	**$130**	**$165**
Dental Services- Trauma[3]	$400 per tooth, U&C for braces	$500 per tooth, U&C for braces	U&C
Dental Services- Replacement[4]	$750	$1,000	U&C
Rates – Dental Accident Insurance	**$8.00**	**$8.50**	**$9.00**

[1]Includes: Inpatient Orthopedic Appliances, X-ray, laboratory tests, Inpatient Physiotherapy, pre-admission tests and all necessary charges other than room and board, for services received during a Hospital Stay
[2]Includes: acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment
[3] For treatment, repair or replacement of injured natural teeth, includes initial braces when required for treatment of covered injury as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma.
[4]Replacement of caps, crowns, dentures, and orthodontic appliances (including braces), fillings, inlays, Crozet appliances, endodontics, oral surgery, examinations and x-ray services as a result of injury

COMMON EXCLUSIONS:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. parachuting;
7. travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. 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;
10. injuries compensable under Workers' Compensation law or any similar law;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. practice or play in Senior High Interscholastic Football, including travelling to and from games and practices.
13. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;
    c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
    d. the Insured Person.

EXCLUDED EXPENSES:

1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;

LIMITATIONS: Any Injury occurring, and expenses incurred there from, as a result of a covered accident which occurs while an Insured is engaged in an activity which is covered under the School's Compulsory Plan, will not be covered under a Voluntary Plan.

SCHOOL TIME COVERAGE

Covers an injury occurring while attending school sponsored and supervised activities such as plays, assemblies, class trips, interscholastic sports (other than Sr. high football), intramural sports, gym and physical education classes. Coverage includes travel to and from school and activities.

24-HOUR COVERAGE

Covers your student for all of the above, plus accidents occurring away from school, in the evenings and on the weekends, vacations, etc.

FULL EXCESS COVERAGE
Benefits are payable for Medically Necessary Covered Expenses that are in excess of amounts payable under any Other Health Care Plan and are subject to the applicable Total Maximum for all Accident Medical Benefits. If the Insured is not covered by any Other Health Care Plan providing Accident Medical Benefits, the excess provision shall not apply, and benefits are payable to the Total Maximum for all Accident Medical Benefits as shown in your Master Insurance Application.

Disclosure
US insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

Fraud Warning
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- To Enroll: Please visit https://www.aliverisk.com/StudentAccidentEnrollment to complete the enrollment form.

How to file a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)
Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

90 Degree Benefits
PO Box 6540
Harrisburg, Pa 17112
Ph: 1-800-427-9308
Fax: (717) 652-8328
Email: Student.Insurance@90degreebenefits.com

Step 1: The Participating Organization (NOT the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Statement.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

Step 2: The Parent/Guardian or Adult Claimant Should:

- Fully answer each item in Part II, including the claimant's personal information, parent's information, along with other insurance information.
- In order to ensure we receive complete claim information, we require providers to submit standardized itemized bills (called "**UB04"** for hospital charges and/or a "**CMS-1500**" for physician charges).
- Providers may bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). **We are Primary over State provided Insurance (i.e. all Medicaid programs) and Non-active Duty TRICARE.**
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment, or zero balance information) claim payment is sent directly to the medical providers.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Helpful information for submitting claims

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will be sent back to injured party, to complete missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- The claimant must seek treatment, resulting in a medical expense, within 90 days of the injury. Contact our office for verification.
- Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Step 3: Submit the Completed Notice of Claim (Claim Form) via either by mail, fax, or email listed above. Please note: if sending information via email, it is only used to receive incoming information. Any questions about claims please call our office.

1. Please Fully Complete This Form
2. See Filing Instructions Attached
3. Mail To

90 Degree Benefits
PO Box 6540
Harrisburg, PA 17112
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: Student.Insurance@90degreebenefits

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity, or Sport:
Claimant's Name (Injured Person)	The Injured Person Was A: ☐ Participant ☐ Staff Member ☐ Other	Date and Time Of Accident:
Place Where Accident Occurred:	Type of Injury: (Indicate Part Of Body Injured - e.g. broken arm, etc.)	
Describe How Accident Occurred - Provide All Possible Details:		
Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Did Accident (Check Yes or No for Each of The Following):

A.	During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?	☐ YES	☐ No
B.	On Activity Premises:	☐ YES	☐ No
C.	While Traveling Directly and Uninterruptedly to Or Form the Activity?	☐ YES	☐ No
D.	During A Participating Organization Practice or Competition?	☐ YES	☐ No
E.	Did Injury Result in Death:	☐ YES	☐ No

Signature of Participating Organization Representative:	Name & Title of Participating Organization Representative:	Date:

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Best Contact Number (Included Area Code):	Social Security Number (Of Injured):	Gender (Of Injured): ☐ M ☐ F	Date of Birth (Of Injured):
Address (in which information should be mailed to):			

Do you/spouse/parent have medical/health care, or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.