

2024-2025

Student Accident & Sickness Insurance

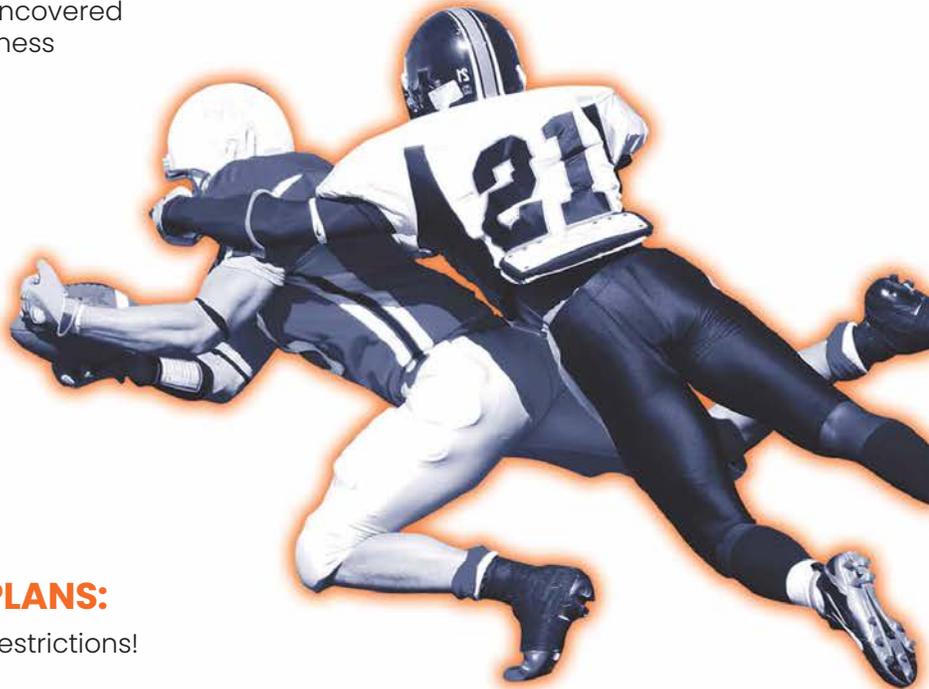
Some families have little or no financial resources to fall back on during an unexpected emergency. Uncovered costs of medical care following an injury or illness may be a serious problem for families.

MYERS-STEVENSON & TOOHEY CAN HELP!

This is why your school provides basic school-time accident coverage for all students. Plus, parents are eligible to take advantage of our optional coverages that provide further insurance protection for your children 24/7. They can even be used to assist with the high co-insurance, deductibles and other cost sharing requirements common to many of today's health plans.

WITH OUR OPTIONAL FULL-TIME PLANS:

- Use the doctor or hospital you want...no restrictions!
- Enhanced Concussion Benefits added
- Enrollment is easy - online, mail and fax
- Every enrollee receives personalized ID cards as proof of coverage



Arranged and Administered by

 **myers | stevens | toohey**



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THE SCHOOL-TIME ACCIDENT PLAN PAID FOR BY YOUR SCHOOL

This will cover Injuries caused by Covered Accidents occurring:

- ✓ On School premises during the hours and on days when the School's regular classes are in session, including one hour immediately before and one hour immediately after regular classes, while continuously on the School premises.
- ✓ While participating in or attending School-sponsored and supervised activities including interscholastic athletic activities.
- ✓ While participating in school-sponsored and supervised multi-day field trips within the U.S. provided that they remain under the general control of school staff and/or school designated adult chaperones
- ✓ While traveling directly and without interruption to or from home and School for regular attendance; or School and off campus site to participate in School-sponsored and supervised activities; and while traveling in School Vehicles at any time.



NOTE – Participation in commercial camps or clinics is not covered under this plan. See “Full-Time 24/7” plans. Coverage period is based on dates selected by the school/district.

Plan Benefits

We will pay benefits only for Covered Injuries sustained or Covered Sickness commencing while insured under this School Year's plan. Benefits payable will be based on the Usual, Customary and Reasonable Charges incurred for covered medical and dental services, as defined by the Policy, subject to exclusions, requirements and limitations. We do not pay for a service or supply unless it is Medically Necessary and listed in the Description of Benefits below. Applicable benefits mandated by the state of residence will be included in the covered expenses.

You may take your child to any provider you choose; however, seeking Treatment through a *First Health* contracted provider may reduce your out-of-pocket costs- see page 10 for details. To find participating *First Health* medical providers nearest you, call 800-226-5116 or log on to www.myfirsthealth.com.

**\$25,000 Maximum per Accident | \$5,000 Maximum per Felonious Assault | \$3,000 Maximum per Emergency Sickness
\$100 Deductible (Disappearing**) Per Covered Accident**

COVERED EXPENSES	BENEFIT MAXIMUMS
Hospital Room & Board - Semi Private Room Rate	100%
Ancillary Hospital Expenses	100%
Intensive Care Unit	100%
Hospital Emergency Room (room & supplies)	100%
Emergency Room Physician Charges	100%
Outpatient Surgical (room & supplies)	100%
Doctor Non-Surgical Treatment & Exam/ Telemedicine (excluding Physical Therapy) Including consultation (when referred by attending Doctor)	100%
Doctor's Surgical Expense	100%
Assistant Surgeon Services	100%
Anesthesiologist Services	100%

COVERED EXPENSES	BENEFIT MAXIMUMS
Physiotherapy (includes related office visits) when prescribed by a Physician	100%
Diagnostic Testing, X-Ray Examinations, MRI and Cat Scans	100%
Ambulance Expenses Ground or Air (from site of an emergency directly to hospital)	100%
Registered Nurse Services	100%
Rehabilitative Braces and Appliances	100%
Out-Patient Prescription Drugs (for Injuries only)	100%
Dental Services (including dental x-rays) made necessary by Injury to whole, sound, and natural teeth for Treatment due to a covered Accident	100%
Eyeglass Replacement (for replacement of broken eyeglass frames or lenses resulting from a covered Accident requiring medical Treatment)	100% to \$750
Aggravations or Re-Injury of an Injury	\$500
Laboratory Procedures	100%

For Field Trip (Specified Trip) Coverage: Medical Evacuation - \$25,000, Repatriation - \$10,000

Additional benefits to this plan may be found on Page 6!

Emergency Sickness means a Sickness of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily functions.

Felonious Assault for psychiatric or psychological counseling. "Felonious Assault" is an act of violence directed against a student, which results in a bodily Injury for which a student requires and seeks medical Treatment, and the School files a written report with the police within 24 hours of the assault.

*Plan does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and do not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

** May be satisfied by other primary insurance.

OPTIONAL PLANS FOR OUR BEST COVERAGE

IMPORTANT: If you'd like to cover your child beyond the school day, you can supplement the School-Time Accident Plan in the previous page with either the Student Accident & Sickness Plan below or the Full-Time (24/7) Accident Plan on the next page.

Student Accident & Sickness Plan

In these challenging times, we are pleased to offer your students 24-hour coverage anywhere in the world for both accidental injuries **AND sickness**.

\$50,000 Maximum per Sickness \$200,000 Maximum per Accident
\$50 Deductible (Disappearing*) Per Condition

1st payment: \$198

(Covers remainder of month in which you enroll and 1 additional month)
Subsequent Payments: \$160.50 a month, billed every 2 months.



Students (Grades P-12) may enroll in this plan. Covers Injuries sustained and Sickness commencing anywhere in the world, 24 hours a day, while your student is insured under this School Year's plan (including interscholastic sports, **except high school tackle football**). This plan does not cover routine or preventative care.

NOTE – Participation in commercial camps or clinics may be covered under this plan.

Coverage begins at 11:59 pm on the day that the Company receives a completed enrollment form and payment of premium.
Coverage ends at 11:59 pm on the last day of the month for which payment has been made. Coverage may be continued for up to 12 calendar months, or through September 30, 2025, whichever comes first, provided the required payments are made.

Plan Benefits

We will pay benefits only for Covered Injuries sustained or Covered Sickness commencing while insured under this School Year's plan. Benefits payable will be based on the Usual, Customary and Reasonable Charges incurred for covered medical and dental services, as defined by the Policy, subject to exclusions, requirements and limitations. We do not pay for a service or supply unless it is Medically Necessary and listed in the Description of Benefits below. Applicable benefits mandated by the state of residence will be included in the covered expenses.

You may take your child to any provider you choose; however, seeking Treatment through a *First Health* contracted provider may reduce your out-of-pocket costs- see page 10 for details. To find participating *First Health* medical providers nearest you, call 800-226-5116 or log on to www.myfirsthealth.com.

COVERED EXPENSES	BENEFIT MAXIMUMS
Hospital Room & Board - Semi Private Room Rate	80%
Ancillary Hospital Expenses	80% to \$4,000/Day
Intensive Care Unit	80%
Hospital Emergency Room (room & supplies)	100%
Emergency Room Physician Charges	100%
Outpatient Surgical (room & supplies)	80% to \$5,000
Doctor Non-Surgical Treatment & Exam/ Telemedicine (excluding Physical Therapy) Including consultation (when referred by attending Doctor)	80%
Doctor's Surgical Expense	80%
Assistant Surgeon Services	80%
Anesthesiologist Services	80%

COVERED EXPENSES	BENEFIT MAXIMUMS
Physiotherapy (includes related office visits) when prescribed by a Physician	80% to \$2,000
Diagnostic Testing, X-Ray Examinations, MRI and Cat Scans	80%
Ambulance Expenses Ground or Air (from site of an emergency directly to hospital)	100%
Registered Nurse Services and Laboratory Procedures	80%
Rehabilitative Braces and Appliances	80%
Out-Patient Prescription Drugs (for Injuries only)	80%
Dental Services (including dental x-rays) made necessary by Injury to whole, sound, and natural teeth for Treatment due to a covered Accident	80%
Eyeglass Replacement (for replacement of broken eyeglass frames or lenses resulting from a covered Accident requiring medical Treatment)	100% to \$750
Aggravations or Re-Injury of an Injury	\$500

* May be satisfied by other primary insurance.

Additional benefits to this plan may be found on Page 6!

OPTIONAL PLANS (CONT.)

Full-Time (24/7) Accident Plan*

This plan will offer your students coverage for **accidental injuries**:

- ✓ Both in and out of school
- ✓ 24 hours a day, 7 days a week
- ✓ Anywhere in the world
- ✓ While participating in all interscholastic sports (except high school tackle football)



Rate for the Entire School Year: \$135

NOTE – Students (grades P-12) and school employees may enroll in this plan. Participation in commercial camps or clinics may be covered under this plan.

Coverage begins at 11:59 pm on the day that the Company receives a completed enrollment form and payment of premium.
Coverage ends at 12:01 am on the date School begins regularly scheduled classes for the 2025-2026 School Year.

Plan Benefits

We will pay benefits only for Covered Injuries sustained or Covered Sickness commencing while insured under this School Year's plan. Benefits payable will be based on the Usual, Customary and Reasonable Charges incurred for covered medical and dental services, as defined by the Policy, subject to exclusions, requirements and limitations. We do not pay for a service or supply unless it is Medically Necessary and listed in the Description of Benefits below. Applicable benefits mandated by the state of residence will be included in the covered expenses.

You may take your child to any provider you choose; however, seeking Treatment through a *First Health* contracted provider may reduce your out-of-pocket costs- see page 10 for details. To find participating *First Health* medical providers nearest you, call 800-226-5116 or log on to www.myfirsthealth.com.

\$50,000 Maximum per Accident

\$0 Deductible Per Condition

COVERED EXPENSES	BENEFIT MAXIMUMS
Hospital Room & Board - Semi Private Room Rate	100%
Ancillary Hospital Expenses	100%
Intensive Care Unit	100%
Hospital Emergency Room (room & supplies)	100%
Emergency Room Physician Charges	100%
Outpatient Surgical (room & supplies)	100%
Physician Non-Surgical Treatment & Exam / Telemedicine (excluding Physical Therapy) Including consultation (when referred by attending Doctor)	100%
Doctor's Surgical Expense	100%
Assistant Surgeon Services	100%
Anesthesiologist Services	100%

COVERED EXPENSES	BENEFIT MAXIMUMS
Physiotherapy (includes related office visits) when prescribed by a Physician	100%
Diagnostic Testing, X-Ray Examinations, MRI and Cat Scans	100%
Ambulance Expenses Ground or Air (from site of an emergency directly to hospital)	100%
Registered Nurse Services and Laboratory Procedures	100%
Rehabilitative Braces and Appliances	100%
Out-Patient Prescription Drugs (for Injuries only)	100%
Dental Services (including dental x-rays) made necessary by Injury to whole, sound, and natural teeth for Treatment due to a covered Accident	100%
Eyeglass Replacement (for replacement of broken eyeglass frames or lenses resulting from a covered Accident requiring medical Treatment)	100%
Aggravations or Re-Injury of an Injury	\$500

Additional benefits to this plan may be found on Page 6!

*Plan does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and do not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

ADDITIONAL PLAN AND FEATURES

Dental Accident Plan (\$75,000 Maximum)

Students (grades P-12) may enroll in this plan.

- Covers Injuries to teeth caused by covered Accidents occurring 24 hours a day, anywhere in the world, including participation in all sports and all forms of transportation.
- **Benefits are payable at 100% of the Usual, Customary and Reasonable charges for Treatment of Injured teeth, including repair or replacement of existing caps or crowns.** We do not pay for damage to or loss of dentures or bridges or damage to existing orthodontic equipment.
- The coverage provides a "Benefit Period" of Accident dental benefits for up to one year from the date of first Treatment. The benefit period for an Injury may be extended each year, provided that: coverage is renewed prior to October 1, the student remains enrolled in grades P-12, and written notice is received by the Company at the time of Injury that further Treatment will be deferred to a later date.

Rate for the Entire School Year: \$12

Coverage Begins at 11:59 pm on the day that the Company receives a completed enrollment form and payment of premium.

Coverage Ends at 12:01 am on the date School begins regularly scheduled classes for the 2025-2026 School Year.



Applies to the School-Time Accident Plan:

EXPANDED MEDICAL BENEFIT

For sports conditions for Treatment of bursitis; sprains; hernia; strains; muscle tears; tendonitis; and repetitive motion injuries if these conditions are aggravated by participation in a Covered Activity



Applies to all plans except Dental Accident

ENHANCED COVERAGE FOR CONCUSSION

If the Insured is diagnosed with a concussion as a result of an Injury received while participating in a Covered Activity, and the Insured is prohibited from participating in Interscholastic Sports as a result of the School's formal concussion protocol, benefits for the treatment of that concussion will be paid at 100% of the Usual, Customary and Reasonable charges with no deductible, subject to all other terms and conditions of the Plan.



Applies to all plans except Dental Accident

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, PARALYSIS, COUNSELING, AND HEART OR CIRCULATORY MALFUNCTION

In addition to medical benefits, if, within 365 days from the date of Accident covered by the policy, bodily Injuries result in any of the following losses, we will pay the benefit set opposite such loss. Only one such benefit (the largest) will be paid for all such losses due to any one Accident.

Accidental Death	\$10,000
Single dismemberment or entire loss of sight in one eye	\$25,000
Double dismemberment or entire loss of sight in both eyes, or paraplegia or hemiplegia or quadriplegia	\$50,000
Counseling - In addition to the AD&D benefits, we will pay 100% of the Usual, Customary and Reasonable costs of psychiatric/psychological counseling needed after covered dismemberment, loss of sight or paralysis up to	\$5,000
Heart or circulatory malfunction death benefit payable for Loss of Life due to Heart, Circulatory or Pulmonary Malfunction that occurs within 72 hours of participation in a covered activity that is causally connected to such Malfunction (not applicable in the State of Nevada)	\$10,000

HOW TO ENROLL IN OUR OPTIONAL PLANS



For IMMEDIATE confirmation of enrollment, skip the steps below and [click here](#) to apply online!

Thank you for enrolling your child! To avoid any delay in coverage, please follow these 3 easy steps below:

Select the plan(s) you wish to purchase below:

- The Student Accident & Sickness Plan will provide our highest level of coverage.
- Our Accident Plans may be purchased on an individual basis or combined with additional coverage (for example, Full-Time Accident + Dental).

Complete the enrollment form below. Please note, we are unable to accept enrollments over the phone.

Purchase and Return You may either:

-  Fax both sides of the completed Enrollment Form to **(949) 348-2630**. You must pay by credit card by completing the payment area below. **Sorry, we cannot accept personal checks or Money Orders by fax.**
-  Mail both sides of the completed Enrollment Form to Myers-Stevens & Toohey, 26101 Marguerite Pkwy, Mission Viejo, CA 92692. You may pay by credit card by completing the payment area below or enclose a check or Money Order made payable to Myers-Stevens & Toohey.

PLEASE DO NOT SEND CASH

2024-2025 Enrollment Form Complete all information (please print) and return to Myers-Stevens & Toohey Co., Inc.



Our BEST Plan

Student Accident & Sickness - 1st Payment \$198

You will be billed \$321 every 2 months thereafter.

Coverage cannot exceed 12 calendar months or run past Sept. 30, 2025.

Our Accident Plans

(One-Time Payment For Entire School Year)

PLANS:	PREMIUM:
Full-Time (24/7)	<input type="checkbox"/> \$135
Dental Accident	<input type="checkbox"/> \$12

Total Amount Due \$

Print Parent or Guardian Name

First Name _____ Last Name _____

I enroll for the coverage checked above. I understand premiums cannot be refunded or converted.

X _____
Parent or Guardian Signature Date

For Residents of California: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of Arizona, Indiana, Missouri, and Nevada: 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, may be subject to prosecution for insurance fraud.

Student Name First Middle Last

Student Birthdate Month Day Year

Mailing Address Apt. #

City State Zip Code

Parent Daytime Phone Number

Parent Email Address

District Name

School Name Grade

ALL PREMIUMS ARE FULLY EARNED UPON RECEIPT AND CANNOT BE REFUNDED OR CONVERTED

Method of Payment Note: \$25.00 service charge for Returned Checks and declined Credit Cards **Check/Money Order** (Make payable to: Myers-Stevens & Toohey Co., Inc.) or **Mastercard or Visa**



Important: If paying by credit card, complete this form. Your amount of charge will appear as "MYERS-STEVENS & TOOHEY 800-827-4695 CA" on your statement.



\$ _____
Amount Card Number Exp. Date MO. YR. 3 Digit Control #

I authorize Myers-Stevens & Toohey Co. Inc. to deduct the premium payment, plus a 3% processing fee, from my credit card. If enrolling in the *Student Accident & Sickness Plan*, I am authorizing the initial premium payment and understand that I will be invoiced every 2 months for the subsequent payments.

X _____
Signature of Cardholder

Auto-Charge Option

Available for your convenience is the option to have your bi-monthly payments automatically charged to your credit card.

By initialing here _____, I hereby authorize Myers-Stevens & Toohey to charge the above credit card \$321, plus a 3% processing fee, on the 5th of the month that my payment is due. This authorization will remain in effect for the 2024/2025 school year until I notify Myers-Stevens & Toohey in writing prior to the next payment date.

FREQUENTLY ASKED QUESTIONS

If I have other insurance, why do I need this coverage?

Our plans can expand your choice of providers for your child and high deductibles, high co-insurance and other cost-sharing obligations common to many of today's health plans.

If my child has no other insurance, what's my best buy?

Unless you need coverage for high school tackle football, the *Student Accident & Sickness Plan* is our broadest, best option. Next best is the *Full-Time 24/7 Accident Plan*.

Under the full-time plans, can I take my child to any doctor or hospital?

YES! However, your out-of-pocket costs could be less using a *First Health* contracted provider (see page 10). To find participating doctors/ hospitals nearest you, call **800-226-5116** or log on to www.myfirsthealth.com

If my child has a covered injury or sickness, will benefits for that same injury or sickness be extended if he/she re-enrolls next year?

Once maximum benefits have been paid or the benefit period ends (generally, from one to two years depending on the plan) no further benefits for that injury or sickness will be made. The *Dental Accident Plan* is the only exception. See this brochure for details.

Are accident-only rates paid every month?

NO! Accident-only rates are one-time charges for the entire School Year.

Does the School-Time plan cover camps and clinics sponsored and organized by groups other than my child's school?

NO! However, such camps and clinics may be covered under our *Full-Time 24/7* or *Student Accident & Sickness* plans. Call us for guidance!

Still need help or have questions?

Go to www.myers-stevens.com or call us for prompt, personalized assistance at (800) 827-4695.



HOW TO FILE A CLAIM

Each claim is assigned to one of our experienced examiners who will diligently guide family members, school staff, medical providers and any other parties involved throughout the entire process from A to Z. Our examiners apply their specific and highly technical knowledge to ensure accurate and expedited processing.

Should an accident or sickness occur, please follow these 4 easy steps:

1. Report School-related Injuries within 72 hours.
2. Obtain a claim form from the School or the Company. Claim forms must be filed with the Company within 90 days after the date of loss.
3. At the same time, please file a claim with any other applicable insurance or Health Care Plan.
4. Follow ALL claim form instructions, attach all itemized bills and send to:



26101 Marguerite Parkway | Mission Viejo, CA 92692-3203
Office 800-827-4695 | Fax 949-348-2630 | claims@myers-stevens.com | CA License #0425842

The Insurance Company

CHUBB®

ACE American Insurance Company
436 Walnut St., Philadelphia, PA 19106

Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit our website at <http://www.chubb.com>. Insurance provided by ACE American Insurance Company and its U.S. based Chubb underwriting company affiliates. All products may not be available in all states. This communication contains product summaries only. Coverage is subject to the language of the policies as actually issued. The terms and conditions of coverage are set forth in the policies issued in the states in which the policy is delivered under form number AH-57720. Surplus lines insurance sold only through licensed surplus lines producers. Chubb, 202 Hall's Mill Road, Whitehouse Station, NJ 08889-1600.

EXCLUSIONS

1. Routine physical examinations and routine testing; preventive testing or treatment; screening examinations or testing in the absence of Injury.
2. Dental care or treatment including damage to or loss of dentures or bridges or damage to existing orthodontic equipment. This exclusion does not apply to care of sound, natural teeth and gums required due to an Injury resulting from an Accident while the Covered Person is insured under the Policy.
3. War or any act of war, declared or undeclared
4. Participation in a Riot; fighting or brawling, except in self-defense; commission of or attempt to commit a felony or violating or attempting to violate any duly enacted law. "Riot" means a public disturbance involving an assemblage of five (5) or more persons which by tumultuous and violent conduct or the threat thereof creates grave danger of damage or injury to property or persons. An exclusion for Riot shall apply only when a person willfully engages in a Riot or willfully incites or urges other persons to engage in a Riot.
Applicable to Nevada only: Participation in a Riot; fighting or brawling, except in self-defense; commission of or attempt to commit a felony (except domestic violence), which results in a conviction. This exclusion does not apply to a Covered Person who is a victim of domestic violence regardless of whether the Covered Person contributed to any loss or injury.
5. Intentionally self-inflicted Injury, suicide or attempted suicide.
6. Injury or Sickness contributed to by the use of alcohol or drugs unless taken in the dosage and for the purpose prescribed by the Covered Person's Doctor. (Not applicable in Nevada)
7. Participation in or practice for interscholastic tackle football; intercollegiate sports; semi-professional sports; professional sports. (except as specified in the Coverage Descriptions) (does not apply to the Dental Accident Plan)
8. Any Injury that is caused by: Flight in, boarding or alighting from an Aircraft, except as a fare-paying passenger or School chartered aircraft, Military Airlift Command or JROTC Program.
9. Any elective treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by Us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
10. Treatment, care or services rendered for an Injury covered by Workers' Compensation Employers' Liability or similar occupational laws. Expenses payable by any automobile insurance policy without regard to fault.
11. Covered medical expenses for which the Covered Person would not be responsible for in the absence of the Policy.
12. Treatment, services or supplies provided by the School's infirmary or its employees, or by medical providers Doctors, or Other Medical Care Providers who work for the School or are contracted or retained by the School. Treatment by persons employed or retained by the Policyholder, or by any Immediate Family or member of the Covered Person's household.
13. Treatment, services or supplies provided or paid for by any governmental program or law, except Medicaid, Medicare or Tricare.
14. Mental or Nervous Disorders.
15. Sickness, disease, bodily or mental infirmity, 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, except as provided by the Policy.
16. Supplies, except as otherwise provided in the Policy.
17. Treatment of osteomyelitis.
18. Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, hernia, detached retina unless caused by an Injury, or mental disorder or psychological or psychiatric care or treatment (except as provided in the Policy).

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including but not limited to, the payment of claims.

Requirements and Limitations

Aggravations of injuries which did not occur while insured under this plan are paid up to \$500 maximum benefit per policy term. School-Time and interscholastic high school tackle football injuries must be reported to the School within 72 hours of the date of Injury. The first Physician's visit must be within 120 days after the Accident occurs. A claim form must be filed with Myers-Stevens & Toohey Co., Inc. within 90 days after the date of first Physician's visit. For School-Time and interscholastic high school tackle football injuries: The plan pays for covered expenses incurred within up to 104 weeks from the date of injury. For Student Accident & Sickness, Full-Time (24/7) and Dental Accident injuries: The plan pays for covered expenses incurred within up to 52 weeks from the date of first treatment (may be extended for certain Injuries). Covered expenses for Emergency Sickness under the School-Time Coverage must be incurred within 24 hours after onset. Each covered condition may be subject to a deductible - see plan details.

Definitions

Accident means a sudden, unexpected and unintended incident. **Covered Accident** means an Accident that results in Injury or loss covered by the Policy. **Coinsurance** means the percentage of Covered Expenses after any Deductible is applied, that are payable under this Policy. **Covered Expenses** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. **Covered Loss** or "**Covered Losses**" means an accidental death, dismemberment or other Injury covered under the Policy. **Disappearing Deductible** means the dollar amount of Covered Expenses the Covered Person must incur before We pay any benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance. The Disappearing Deductible is shown on the Schedule of benefits. **Emergency Sickness** means a Sickness of such a nature that failure to get immediate medical care could put the person's life in danger or cause serious harm to the person's bodily functions. **Injury** means accidental bodily harm sustained by a Covered Person that results directly from an Accident (independently of all other causes) and occurs while coverage under the Policy is in force. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. **Medically Necessary** or **Medical Necessity** means the services or supplies provided by a Hospital, Doctor, or other provider that are required to identify or treat an Injury and that, as determined by The Company, are: (1) consistent with the symptom or diagnosis and treatment of Injury or Sickness; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Person; and (4) the most appropriate supply or level of service that can be safely provided. When applied to the care of an Inpatient, it further means that the Person's medical symptoms or condition requires that the services cannot be safely provided as an outpatient. The fact that a Doctor may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Policy. **Other Valid and Collectible Insurance** means any: 1) group plan, program, or insurance policy; 2) any other group hospital, surgical or medical benefit plan; or 3) union welfare plans or group employer or employee benefit programs. Other Valid and Collectible Insurance will not include benefits provided by the United States Social Security Act, any individual health insurance plans or any individual disability insurance plans. **School Activity** means any activity that is sponsored and supervised by the School. It does not include camps or clinics relating to athletics or cheerleading that are sponsored, controlled and, or organized by any non-School group. **Sickness** means an illness, disease or infection commencing while coverage under the Policy is in force. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness. **Usual, Customary and Reasonable Charge** means the prevailing amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Non-Duplication of Benefits (Excess Provision)

In order to keep premiums as affordable as possible, these plans pay benefits on a non-duplicating basis. This means, if a person is covered by one or more of these plans and by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount. (In Arizona: Does not apply to the Sickness-Only coverage under the Student Accident & Sickness Plan.)

PRIMARY COVERAGE WAIVER

Failure by a Covered Person to follow the terms and conditions of his or her primary coverage will result in a benefit reduction of Covered Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment.

IMPORTANT NOTICE: This brochure contains a brief description of the benefits available under the insurance programs. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policies delivered in the state under form numbers AH-57720. Complete details may be found in the policies. CERTAIN INSURANCE PLANS DESCRIBED HEREIN PROVIDE SHORT-TERM LIMITED DURATION SICKNESS BENEFITS. THEY DO NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE") AND DO NOT SATISFY A PERSON'S INDIVIDUAL OBLIGATION TO SECURE THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT (ACA). FOR MORE INFORMATION ABOUT THE ACA, PLEASE REFER TO WWW.HEALTHCARE.GOV.

ALL PREMIUMS ARE FULLY EARNED UPON RECEIPT AND CANNOT BE REFUNDED OR CONVERTED

For assistance in Spanish, please call 800-827-4695 | Para asistencia en Español, por favor llame a 800-827-4695

Student Accident & Sickness Insurance CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)



Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. Coverage summaries may be obtained from school/parish authorities, printed brochures used to secure coverage, online, or by contacting us directly at (800) 827-4695.



Claim form and reporting

Report school/parish related injuries immediately to school officials, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized school/parish official to **completely and clearly** fill out Part A of the form. If the reported injury is not school/parish-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.

Completely and clearly fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.



Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.myfirsthealth.com (800) 226-5116 or (in the State of Washington only) www.fchn.com (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school/parish-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.



When treatment is sought

- Give the provider's billing/admissions department your primary insurance/health plan information (if applicable).
- If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school/parish, let the billing department know that and identify the district, Diocese or other school system involved and the specific school/parish. In either case, explain that your child has medical expense insurance that provides benefits on an excess or secondary basis and that it is NOT what is sometimes referred to as "third party" insurance. The student is the insured.
- Request the billing department to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.



If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.



What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE— we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*



Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

MYERS-STEVENS & TOOHEY
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA 92692

OR

Fax: (949) 348-9350

OR

Email: claimsinfo@myers-stevens.com

STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

PART A SCHOOL/PARISH STATEMENT (Parent or legal guardian may complete Part A if injury is not school/parish-related)

NAME OF CLAIMANT		FIRST	MI	LAST	AGE	GRADE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH	
								MO	DAY
								YR	
ADDRESS OF CLAIMANT			CITY		STATE		ZIP CODE		
IS THE CLAIMANT A:						ID # FROM ID CARD (if applicable)			
<input type="checkbox"/> STUDENT <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER _____									
NAME OF SCHOOL/PARISH					NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM				
SCHOOL/PARISH MAILING ADDRESS			CITY		STATE		ZIP CODE		SCHOOL CONTACT EMAIL ADDRESS
DURING WHAT ACTIVITY DID THE INJURY OCCUR? <input type="checkbox"/> INTERSCHOLASTIC PRACTICE <input type="checkbox"/> INTERSCHOLASTIC GAME <input type="checkbox"/> P.E. <input type="checkbox"/> CLASSROOM <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> TRAVEL <input type="checkbox"/> AT HOME <input type="checkbox"/> FIELD TRIP <input type="checkbox"/> RELIGIOUS EDUCATION <input type="checkbox"/> CONFIRMATION <input type="checkbox"/> YOUTH MINISTRY <input type="checkbox"/> YOUNG ADULT MINISTRY <input type="checkbox"/> CYO <input type="checkbox"/> PAL <input type="checkbox"/> OTHER _____									
WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST NAME OF SPORTS ORGANIZATION: _____				TYPE OF SPORT: _____		DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, name of plan: _____			
DATE OF INJURY/SICKNESS	TIME OF INJURY		WHAT PART AND/OR AREA OF THE BODY WAS INJURED?			HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN?			
	A.M. / P.M. (Circle One)		<input type="checkbox"/> RIGHT _____ <input type="checkbox"/> LEFT _____ <small>(Additional details may be provided below)</small>						
PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC 									
NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY			WAS HE/SHE A WITNESS TO THE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			DATE SCHOOL/PARISH WAS NOTIFIED			
NAME AND TITLE OF OFFICIAL COMPLETING FORM			SIGNATURE		DATE SIGNED		SCHOOL/PARISH TELEPHONE NUMBER		
			X						

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN		ADDRESS			PHONE NUMBER	
IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF PLAN(S) _____				POLICY NUMBER(S)		IS THE CLAIMANT A MEDICARE BENEFICIARY? <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF CLAIMANT'S EMPLOYER (if applicable)		ADDRESS			PHONE NUMBER	
NAME OF FATHER OR LEGAL MALE GUARDIAN		EMAIL ADDRESS		MOBILE TELEPHONE NO.		HOME TELEPHONE NO.
ADDRESS		CITY		STATE		ZIP CODE
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed				WORK TELEPHONE		
ADDRESS OF EMPLOYER		CITY		STATE		ZIP CODE
NAME OF MOTHER OR LEGAL FEMALE GUARDIAN		EMAIL ADDRESS		MOBILE TELEPHONE NO.		HOME TELEPHONE NO.
ADDRESS		CITY		STATE		ZIP CODE
NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed				WORK TELEPHONE		
ADDRESS OF EMPLOYER		CITY		STATE		ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFR 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and/or civil penalties. I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

STATE-SPECIFIC FRAUD WARNINGS

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

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment for 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, Washington: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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 \$5,000 and the stated value of the claim for each violation.

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.

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.

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.

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



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