Up to **$1,000,000** Student Accident Medical Insurance Protection

Administered By:
LEFEBVRE INSURANCE, LLC
850 Franklin Street, Wrentham, MA 02093
(800) 451-9668

2014-2015

Underwritten By:
ACE American Insurance Company
Philadelphia, PA 19106

(Form ME)
Important Notice: The Plan does not provide benefits for sickness of any kind.

24 Hour Accident Coverage

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $50.00

SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees. Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $11.00

CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). You will receive a claim form which must be filed with the Company within 90 days after the accident. Covered Excess Expenses incurred within one year from the accident will be considered. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

Direct All Questions and Correspondence To:

LEFEBVRE INSURANCE, LLC
850 Franklin Street, Wrentham, MA 02093
(800)451-9668

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. DO NOT SEND CASH.

Optional $50,000 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide benefits 24 hours a day for the Usual & Customary Expenses incurred within 2 years from the date of the covered Injury. Also included in this benefit are the following services:

1. Replacement of caps, crowns, dentures, and orthodontic appliances, (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the Usual & Customary charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the initial benefit paying period. No bills will be paid without written certification. Services must commence within 90 days from the date of Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel.. . . . . $8.00

This coverage **cannot** be purchased without School Time or 24 Hour coverage.

Accidental Death & Dismemberment

When Injury shall result in any one of the following losses within 180 days from the date of accident, the company will pay for loss of:

Life $5,000

Both hands or both feet or the
entire sight of both eyes $20,000

One Hand and One Foot $20,000

Either One Hand or One Foot and

the Entire Sight of One Eye $20,000

One Hand or One Foot or the entire
sight of one eye $10,000

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of thumb or index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics / activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

ACCIDENT INSURANCE PROTECTION
PROVIDING A MAXIMUM OF $1,000,000 MEDICAL EXPENSE

The company will pay Usual and Reasonable Expenses incurred for a covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 52 weeks from the date of the Injury.

MAXIMUM BENEFITS

Hospital Services:

Daily Room & Board (Semi-private) . . . . . Avg. Semi-Private Rate Up to $500/day

Intensive Care Room & Board . . . . . $750/Day not to exceed 7 days

Miscellaneous Services:

During Hospital Confinement or when surgery is performed. . . . . 75% of Usual & Customary to $10,000

Emergency Room outpatient: when Hospital Confinement is not required $250.00

Doctor's Services:

Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of . . . . . $140.00 unit value Maximum $10,000

Anesthesia: (including administration) and assistant surgeon: % of surgical allowance 30%

Doctor visits other than for physiotherapy or similar treatment when no surgery benefit is paid . . . . . Usual & Customary

Consultants (when required by attending physician for confirmation or determining a diagnosis, but not for treatment) and second opinion: $100.00

Laboratory & X-Ray Services:

Other than Dental and including fee for interpretation and/or reading of X-Ray
X-ray when not Hospital Confined X-Ray $500.00
Lab $500.00

MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading $500.00

Additional Services:

Physiotherapy or similar treatment:

In-Hospital $500.00

Out of Hospital. $500.00

Chiropractic Services (in or out of hospital) $100.00

Registered Nurse (in or out of hospital) . . . . . Usual & Customary

Ambulance to initial treatment facility . . . . . Usual & Customary

Orthopedic Appliances:

In-hospital $500.00

Out of hospital $500.00

Outpatient drugs & medication Administered by a Doctor . . . . . Usual & Customary

Eyeglasses, contact lenses and hearing aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered Injury. $300.00

Dental Services:

For treatment, repair or replacement of injured natural teeth, includes initial braces when required for treatment of a covered Injury, as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma. . . . . $400 / tooth Maximum $12,800

FULL EXCESS COVERAGE

Benefits are payable for covered expenses that are not recoverable from another Plan Providing Accident Medical Expense Benefits to the applicable accident medical maximum. If the Insured is not covered by another Plan Providing Accident Medical Expense Benefits, the excess provision shall not apply, and benefits are payable to the accident medical expense maximum described in this brochure.

EXCLUSIONS AND LIMITATIONS

Exclusions: The policy does not cover any loss incurred as a result of;

1. Service or Treatment rendered by a Physician, nurse or any other person Who is: (a) employed or retained by You; or (b) who is the Insured or a member of his/her Immediate Family member.
2. Charges which (a) the Insured would not have to pay if he/she did not have insurance; or (b) are in excess of Usual and Customary Expenses.
3. Intentionally self-inflicted Injury or suicide; Injury caused by war or Act of war, or caused by taking part in a riot or civil disturbance.
4. Any Injury that is caused by (a) flying in aircraft, except as a fare paying passenger, (b) para-chuting; travel in or upon a snowmobile or any two or three wheeled motorized vehicle or any off road motorized vehicle not requiring licensing as a motor vehicle.
5. Any Injury for which the Insured is covered under Worker's Compensation or Employer Liability Laws.
6. That part of medical expenses payable by any automobile insurance policy without regard to fault (does not apply in any state that prohibits such limitation.)
7. The Insured's part in committing or attempting to commit an unlawful act; fainting, congenital conditions, birth defects, complications or aggravation of pre-existing conditions, Osgood Schlatter's disease or similar conditions.
8. An Injury that is: (a) the result of the Insured being intoxicated; or (b) caused by use of any narcotic unless administered by or upon the advice of a Physician.
9. A sickness or disease, or Diagnostic Test or treatment, except infection which occurs directly from an accidental cut or wound, or ingestion of contaminated food.
10. Injuries sustained as a result of taking part in High School Football, including traveling to and from games and practice, unless specifically provided for in the school's master application.
11. Expenses incurred in connection with plastic or cosmetic surgery or procedures unless required by an Injury which occurred while the Insured was covered.
12. Any Injury resulting from participation in or practice for non-school sponsored skiing, ice hockey, soccer or tackle football, unless specifically provided for in the school's master application.
13. Eyeglasses, contact lenses, eye refraction or prescriptions therefore; except for the usual and reasonable charge for replacement of broken eyeglasses, broken frames or broken lenses resulting from a covered accident. Routine refraction and routine eye examinations are not covered under the policy.
14. Overuse symptoms, bursitis, tendinitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjuries of the aggravation thereof.
15. Benefits will not be duplicated if an Insured is covered under more than one Student Accident plan of coverage issued by us.

LIMITATIONS: An Injury occurring, and Expenses incurred therefrom, as a result of an 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. The maximum payable for Expenses incurred as a result of an accident involving a motor vehicle shall be limited to $5,000 for any one accident, subject to exclusion #6. When Excess Insurance is provided and another Plan Providing Medical Expense Benefits to an Insured is an HMO, PPO, or similar arrangement for provision of benefits or services, and the accident occurs within the geographic area of the HMO, PPO, or similar arrangement for benefits of services and the Insured does not use the facilities or the HMO, PPO, or similar arrangement for provision of benefits or services, the medical benefits otherwise payable under the Policy shall be reduced by 50%. This limitation shall not apply to emergency treatment required within 24 hours after an accident or when the accident occurs outside the geographic area served by the HMO, PPO, or similar arrangement for provision of benefits or services. NOTE: It is not the intent of the Company to unfairly reduce benefits for any Insured if the Insured is outside the Network Area of their HMO, PPO, or similar arrangement for benefits, and no benefits are available. The reduction of benefits is only for those Insureds who can use their HMO, PPO, etc. and have not done so.

To File A Claim:

1. Use attached claim form
2. Fill out all necessary information
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

Proof of Loss is required within 90 days from the date of the Accident. You have ONE year from the time Proof of Loss would have been required to file a claim. Claims submitted past this period will not be considered for payment under the policy.

ENROLLMENT FORM CHECKLIST

Did You:

❒ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)
❒ Check the appropriate box(s) for the coverage you have selected.
❒ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

For questions, inquiries, and information contact:

Lefebvre Insurance, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

DO NOT SEND CASH

Enrollment Form

Please Print **2014-2015 ME**

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS APT#

CITY ST ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form 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 act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – 2014-2015 CHECK ✓ YOUR SELECTION

Coverage Plans	Premiums
24-Hour – Including Extended Dental	☐ $58.00
24 Hour Only	☐ $50.00
School Time Only – Including Extended Dental	☐ $19.00
School Time Only	☐ $11.00

Make checks payable to:

ACE American Insurance Company

How to Enroll

1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to ACE American Insurance Company shown for the correct amount.
3. Mail envelope to Lefebvre Insurance, LLC. – 850 Franklin Street – Wrentham, MA 02093. Your cancelled check or money order stub will be your receipt and confirmation of payment. (Please write the student's name and school name on your check.)

(ME) **Ver. 3**

MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

MCA ADMINISTRATORS, INC.

P.O. BOX 6540
HARRISBURG, PA 17112

ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS
UNDERWRITTEN BY: ACE AMERICAN INSURANCE COMPANY

CLAIM ASSISTANCE:
1-800-427-9308

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A. POLICY HOLDER

(1) Name of School District/College/Organization | Individual School/Team | (2) County

(3) Address of School: (Street) | (City) | (State) | (Zip) | (4) Area Code - Telephone # | (5) Date of Injury MO DAY YR

(6) Name of Injured Person | (7) Date of Birth MO DAY YR | (8) Social Security # | (9) Age | (10) Grade | (11) MALE ☐ FEMALE ☐

(12) Injury occurred: Practice ☐ Game ☐ P.E. ☐ Travel ☐ Classroom ☐ At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐ | (13) Type of Sport:

(14) Describe in detail HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.

(15) What part of the body was injured: (Left or Right side if applicable) | (15a) Time of injury ____:____ a.m. ____:____ p.m.

(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐

(17) Name of Supervisor (If different from organization official) | (18) Was he/she a witness to accident? Yes ☐ No ☐

(19) Signature of School or Organization Official | (20) Title of Official | (21) Date Signed MO DAY YR

PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

(1) Name of Mother/Father or Guardian | (2) Social Security # | (3) Relationship to insured ☐ Father ☐ Mother ☐ Guardian ☐ Self

(4) Address (Number) Street (Lot or Apt. No.) | (5) City | (6) State | (7) Zip Code

(8) Area Code – Home Telephone Number | (9) Father's work telephone ( ) _____ Mother's work telephone ( ) _____

(10) Occupation of Father or Mother, Wife or Husband | (11) Place of Employment | (12) Address of Employer

(13) Occupation of Self (if over age 18) | (14) Place of Employment | (15) Address of Employer

(16) Do you have any other health and/or accident insurance plan (other than this plan?)
Father: ☐ YES ☐ NO Mother: ☐ YES ☐ NO Husband: ☐ YES ☐ NO Wife: ☐ YES ☐ NO Self: ☐ YES ☐ NO

(17) Is the injured person covered by other health and/or accident insurance plan? ☐ YES ☐ NO Effective Date MO DAY YR | (18) Name of other health and accident insurance company

(19) Address of Insurance Company | (20) Policy Number | Phone #

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, government agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administration to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the Policy identified above and that a copy of this Authorization shall be considered as valid as the original.
I agree that a photographic copy of this authorization shall be valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to intent to revoke.

Signature of Insured or Authorized Representative | Dated

Address

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

Date | Signature of Responsible Party or Student if 18 years old

Fraud 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.

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.

2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.

3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator at the top of the claim form: **paid receipts and/or balance due statements are not accepted.**

4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, etc., and forward to the claim administration for processing.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of 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.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).

2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.

3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THIS POLICY

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)

5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.