WEST CHESTER AREA SCHOOL DISTRICT

August 2019

TO: ***Student Athletes and Parents/Guardians***
Secondary Principals
Athletic Directors
Coaches & Advisors

2019-20 STUDENT ACCIDENT INSURANCE Coverage for Interscholastic Sports/Activities

The District provides accident insurance coverage for all students while participating in scheduled school-sponsored and school-supervised middle and high school Interscholastic Sports, Bands, Majorettes, Cheerleaders, and while acting as student coaches, student trainers, and student managers. For the complete summary of benefits, please visit the District website at www.wcasd.net and click on the ***For Parents*** drop down tab. Information may be accessed by clicking on the ***Insurance, Student Accident Insurance for Interscholastic Sports*** link.

*If accident insurance coverage is desired while not a participant in one of these activities, additional insurance may be purchased at parents' expense. (School-time only accident insurance: $28 per school year **or** 24-hour accident insurance coverage: $124 per school year.) To download the application form, please visit the District website at www.wcasd.net and click on the **For Parents** drop down tab, and click on the **Insurance, Optional Student Accident** link. Parents may also call AG Administrators at 610-933-0800 or email requests for information to info@agadm.com.* (All parents will receive a separate communication from the District regarding this insurance.)

INSTRUCTIONS FOR
INTERSCHOLASTIC SPORTS/ACTIVITIES CLAIMS
Use Policy #US1275521

Claims must be filed with the insurance company within 90 days from the date of injury. *Claim forms are available on the District website.* Please visit www.wcasd.net and click on the ***For Parents*** drop down tab. The claim form and instructions for filing a claim may be accessed by clicking on the ***Insurance, Student Accident Insurance for Interscholastic Sports*** link. The claim form and all bills must be forwarded to the claims administrator. The address is:

A-G Administrators, Inc.
Claims Department
P. O. Box 979
Valley Forge, PA 19482
Phone (610) 933-0800
Or (800) 634-8628 Toll Free

If HELP IS NEEDED PRIOR TO FILING A CLAIM, call A-G Administrators, Inc. using either one of the telephone numbers listed above.

WEST CHESTER AREA SCHOOL DISTRICT
ATHLETIC ACCIDENT COVERAGE
SUMMARY OF BENEFITS

MEDICAL EXPENSE BENEFIT

Hospital Room & Board Daily Maximum Benefit Amount:	URC per day
Intensive Care Room & Board Daily Maximum Benefit:	URC per day
Hospital Miscellaneous Maximum Benefit Amount:	URC per day
Outpatient Pre-Admission Testing Benefit Amount:	URC
Outpatient Hospital Emergency Room Treatment Maximum Benefit Amount:	URC
Surgical Benefits	
Primary Surgeons Maximum Benefit Amount:	URC
Assistant Surgeon, Second Surgical Opinion, Consultation Maximum Benefit:	URC
Anesthesia Maximum Benefit:	URC
Surgical Facility Maximum Benefit per Operating Session:	URC
Doctor's Visits	
In-Hospital Maximum Benefit:	URC per visit
Office Visits Maximum Benefit:	URC per visit
Maximum for All In-Hospital and Office Doctor's Visits:	N/A
X-ray and Laboratory Maximum Benefit Amount:	URC per procedure
Nursing Maximum Benefit Amount:	URC per injury
Physiotherapy Benefit	
Maximum Benefit Amount (Hospital Inpatient):	URC
Maximum Benefit Amount (Outpatient):	URC
Maximum for All Physiotherapy Combined (Inpatient & Outpatient):	N/A
Ambulance Maximum Benefit Amount:	URC
Medical Equipment Rental Charges Maximum Benefit Amount:	URC
Medical Services and Supplies Maximum Benefit Amount (Blood, Blood Transfusions, Oxygen):	URC
Expanded Medical Benefit for Covered Sports Conditions	
Covered Sports Condition: Repetitive Motion Injuries, Strains, Sprain Hernia, Tennis Elbow, Tendonitis, Bursitis, and Muscle tears	URC
Heart and Circulatory Conditions	
Covered Heart and Circulatory Conditions: heart attack, stroke Brain circulatory malfunctions and heat exhaustion	URC
Dental Treatment for Injury Only	
Maximum Benefit Amount:	URC
Out-Patient Prescription Drug Benefit	
Maximum Benefit Amount:	URC
Eyeglasses, Contact Lenses, Hearing Aids Related to a covered Accident Only For replacement only	URC
Accidental Death Benefit	
Principal Sum:	$10,000
Accidental, Dismemberment, Loss of Sight	
Principal Sum:	$20,000

Exclusions

Benefits will not be paid for a Covered Person's loss which:

1) Is caused by or results from the Covered Person's own:
   a) Intentionally self-inflicted Injury, suicide or any attempt thereat.
   b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded);
   c) Commission or attempt to commit a felony;
   d) Participation in a riot or insurrection;
   e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
   f) Driving while intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;
2) Is caused by or results from:
   a) Declared or undeclared war or act of war;
   b) An Accident which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days);
   c) Aviation, except as specifically provided in this Certificate:
   d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted, unless a Sickness Expense Rider is in force under this Certificate. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.
   e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
      i) The loss was caused by fire heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
      ii) The Covered Person was within a 25-mile radius of the site of the release either:
         (1) At the time of the release; or
         (2) Within 24 hours of the start of the release.

ADDITIONAL EXCLUSIONS

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

How to File a Claim

To process your claim please submit the following three pieces of information:

1. Completed and Signed Claim Form
2. Itemized Bills
3. Explanation of Benefits from your Primary Insurance Carrier

These documents should be mailed, emailed or faxed to:

A-G Administrators, Inc.
Claims Department
P.O. Box 979
Valley Forge, PA. 19482
Claims1@agadm.com

(610) 933-4122 Fax
(610) 933-0800 Phone
(800) 634-8628 Toll Free

1. The Claim Form enables us to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure the "other insurance" portion of the claim form is completed in full. The claim form must be signed by a school official such as coach or athletic trainer.

2. Itemized Bills: Please include copies of all medical bills, showing the name and address of the provider of service, date of service, type of service and the charges. Account statements or "balance due" statements are helpful, but do not contain all the information needed to process the charges.

3. Explanation of Benefits: If you have other medical insurance, all medical bills must be first submitted to that carrier for their determination of eligibility. If the charges are not paid in full by the other medical insurance carrier we will need to see a copy of the "Explanation of Benefits" from that carrier prior to issuing benefits from this office. If you have no primary medical insurance the need for an "Explanation of Benefits" will not be applicable to your claim.

P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Student Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

Policyholder (School) _____

Student's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex ❑ M ❑ F SOCIAL SECURITY #

Cell Phone _____ Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ Accident Date _____

Body Part Injured _____ Place of Accident _____

Nature of Injury — Details of What Happened _____

_____

_____

INSURANCE INFORMATION

Does the claimant have primary insurance? ❑ Yes ❑ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____
STUDENT SIGNATURE *(Parent or guardian, if participant is a minor)* Date

_____ _____ _____
AUTHORIZED POLICYHOLDER REP. SIGNATURE Title Date

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: 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.

Colorado Residents: 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.

District of Columbia Residents: 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 Residents: 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.

New York Residents: 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.

Tennessee Residents: 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.

Virginia Residents: 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 claim containing a false or deceptive statement may have violated state law.