# K-12 Voluntary Student Accident Insurance up to \$250,000

## 2023-2024



Administrative Office A-G Administrators LLC Berwyn, PA USA Phone (610)933-0800 www.agadministrators.com

Plans are Underwritten by United States Fire Insurance Company



## K-12 Accident Insurance

#### **Unexpected Accidents Can Happen**

This brochure explains how you can help guard against certain unexpected events. Our plans are designed to help supplement any insurance you have by satisfying deductibles or co-insurance requirements, or limiting the possible financial impacts of an injury if you have no other insurance. Remember that the more active your child is, the more valuable this coverage can be.

## **Choose Your Coverage Plan**

**24-Hour Coverage (Accident Only)** – This plan provides around the clock coverage to your child 24hours a day, while he or she is in school, at home or away. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the opening of the next school term. **Excludes all interscholastic sports.** (\$90.00)

**School Time Coverage (Accident Only)** – This plan provides coverage to your child while he or she is on school premises, during school hours/days, attending school sponsored and supervised activities including travel directly without interruption between the student's residence and school/activity with transportation furnished by the school. Coverage is provided from the effective date of the insured student's coverage for which premium has been received by A-G to the end of the regular school term. **Excludes all interscholastic sports.** (\$22.50)

## **Description of Benefits**

below, excess of \$15,000 payable at 100 Usual, Reasonable and Customary Charg 50 ienefit Period: 52 Weeks dospital Services Miscellaneous Hospital Services: During hospital confinement \$3,000 per day Aliscellaneous Hospital Services: During hospital confinement \$3,000 per day, not to exceed 10 days mergency Room Charges: When hospital confinement is not required \$400 Maximum mergency Room Charges: If out-patient surgery is required, the maximum is ncreased to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.) hysician Services urgery: including pre- and post-operative care <sup>4</sup> \$170 Unit Value mesthesia: 40% of the Surgery Benefit Paid diftion to Surgery Benefit and Adv% of the Surgery Benefit Paid diftion to Surgery Benefit and Specialists aborator's Misit: other than for Physiotherapy or similar treatment not payable in diftion to Surgery Benefit and Specialists aborator's Misit: and Specialists aborator's and X-Ray Services Other than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value diftional Services Mysiotherapy or similar treatment, including pre-treate is demonstrated) diftional Services Dother than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value ab and X-Ray: (when no fracture is demonstrated) diftional Services Mysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anipulation, Massage and Heat Legistered Nurse: 100% UCR imbulance Transportation: (Ground Only) Si300 Maximum Dut-Patient Drugs and Medication: Administered in Doctor's office or by rescription ooth which was sound and natural at the time of injury yeglasese, Contact Lenses: Replacement of orken glasses and/or frames, contact enses, resulting from a covered injury vectored to pathene of injury	Benefit	24 Hour Coverage/School Time Coverage
below, excess of \$15,000 payable at 100 Usual, Reasonable and Customary Charg \$0 tenefit Period: 52 Weeks tospital Services Miscellaneous Hospital Earvices: During hospital confinement \$3,000 Aliscellaneous Hospital Services: During hospital confinement \$3,000 thensive Care: When confined to a Hospital Intensive Care Unit \$700 per day, not to exceed 10 days mergency Room Charges: When hospital confinement is not required \$400 Maximum imergency Room Charges: When hospital confinement is not required \$400 Maximum intersive Sahom below.) thysician Services urgery: including pre- and post-operative care <sup>4</sup> those Status Surgeon: \$1,500 Maximum intensive Sahom below.] thysician Services urgery: including pre- and post-operative care <sup>4</sup> those Status Surgeon: \$1,500 Maximum intersives Show below.] thysician Services urgery: including pre- and post-operative care <sup>4</sup> those Surgical Option, Consultation and Specialists aboratory and X-Ray Services Other than for Physiotherapy or similar treatment not payable in diftion to Surgery Benefit Paid aboratory and X-Ray Services Other than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value tab and X-Ray: (when no fracture is demonstrated) thysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anipulation, Massage and Heat tegistered Nurse: Mubulator, Transportation: (Ground Only) S100 Maximum S100 Maximum S1	Benefits provided for all enrolled students of the Policyholder excluding interschol	astic sports for whom premium is paid.
Identifit Period: 52 Weeks   Idoptial Services 5300 per day   Daily Room & Board: Semi Private Room \$300 per day   Discellaneous Hospital Services: During hospital confinement \$300 per day   Discellaneous Hospital Services: When hospital confinement is not required \$400 Maximum   imergency Room Charges: If out-patient surgery is required, the maximum is \$1,500 Maximum   increased to (The benefits are payable in addition to the X-rays and surgeon's shown below.) \$170 Unit Value   Mysician Services 40% of the Surgery Benefit Paid   Doctor's Visit: other than for Physiotherapy or similar treatment not payable in doix of the Surgery Benefit Paid 100% UCR   Mon-Surgical Opinion, Consultation and Specialists \$150 aggregate benefit   aboratory and X-Ray Services \$20 Unit Value   Widtional Services \$20 Unit Value   Why Iotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Maximum of \$500 \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   Viditional Services 100% UCR   Why Iotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Maximum of \$500 \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   Vut-Patient	Maximum Benefit:	\$250,000; \$15,000 payable as shown below, excess of \$15,000 payable at 100% Usual, Reasonable and Customary Charges
iospital Services \$300 per day   Aliy Room & Board: Semi Private Room \$300 per day   Aliscellaneous Hospital Services: During hospital confinement \$3,000   Intensive Care: When confined to a Hospital Intensive Care Unit \$700 per day, not to exceed 10 days   Imergency Room Charges: When hospital confinement is not required \$400 Maximum   Imergency Room Charges: If out-patient surgery is required, the maximum is \$1,500 Maximum   nerceased to (The benefits are payable in addition to the X-rays and surgeon's \$1,500 Maximum   hysician Services \$170 Unit Value   urgery: including pre- and post-operative care* \$170 Unit Value   hysician Services \$170 Unit Value   Nesthesia: 40% of the Surgery Benefit Paid   loon-Surgical doctor's charges in the emergency room \$70 per visit   econd Surgical Option, Consultation and Specialists \$150 aggregate benefit   aboratory and X-Ray Services \$100% UCR   Other than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   viditional Services 100% UCR   Unplances: When ordered by attending physician \$500 Maximum   tystotherapy or	Deductible:	\$0
baily Room & Board: Semi Private Room\$300 per dayMiscellaneous Hospital Services: During hospital confinement\$30,00Intensive Care: When confined to a Hospital Intensive Care Unit\$700 per day, not to exceed 10 daysimergency Room Charges: When hospital confinement is not required\$400 Maximumimergency Room Charges: If out-patient surgery is required, the maximum is care add to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.)\$1,500 Maximumhysician Services\$170 Unit Valuewrgery: including pre- and post-operative care*\$170 Unit Valueunesthesia:40% of the Surgery Benefit Paidvisits that Surgeon:40% of the Surgery Benefit Paidobcrtor's visit: other than for Physiotherapy or similar treatment not payable in ddition to Surgery Benefit100% UCRaboratory and X-Ray Services\$150 aggregate benefitOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 Maximumviditional Services100% UCRHysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Aanipulation, Massage and Heat\$500 MaximumUnthysiotherapy or similar treatment: including physician\$500 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by rescription\$200 per toothDut-Patient Drugs and Medication: Administered in Doctor's office or by rescription\$200 per toothveglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact snew\$100 maximum <tr< td=""><td>Benefit Period:</td><td>52 Weeks</td></tr<>	Benefit Period:	52 Weeks
Miscellaneous Hospital Services: During hospital confinement \$3,000   Intensive Care: When confined to a Hospital Intensive Care Unit \$700 per day, not to exceed 10 days   imergency Room Charges: When hospital confinement is not required \$400 Maximum   imergency Room Charges: If out-patient surgery is required, the maximum is \$1,500 Maximum   increased to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.) \$1,500 Maximum   thysician Services 40% of the Surgery Benefit Paid   Vasciestant Surgeon: 40% of the Surgery Benefit Paid   boctor's Visit other than for Physiotherapy or similar treatment not payable in ddition to Surgery Benefit 100% UCR   bon-Surgical doctor's charges in the emergency room \$70 per visit   econd Surgical Opinion, Consultation and Specialists \$100 maximum   aboratory and X-Ray Services 0   Uther than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   Viditional Services 100% UCR   thysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Maximum of \$500 \$50/Treatment   Mainpulation, Massage and Heat Maximum \$300 Maximum   Dut-Patient Drugs and Medicat	Hospital Services	
ntensive Care: When confined to a Hospital Intensive Care Unit \$700 per day, not to exceed 10 days   imergency Room Charges: When hospital confinement is not required \$400 Maximum   imergency Room Charges: If out-patient surgery is required, the maximum is nor recreased to (The benefits are payable in addition to the X-rays and surgeon's \$1,500 Maximum   increased to (The benefits are payable in addition to the X-rays and surgeon's \$170 Unit Value   urgery: including pre- and post-operative care* 40% of the Surgery Benefit Paid   vesthesia: 40% of the Surgery Benefit Paid   vestical cotor's Visit: other than for Physiotherapy or similar treatment not payable in ddition to Surgery Benefit Paid 100% UCR   vecond Surger Benefit \$100 not ucreated to (Adv Services) \$200 Unit Value   aboratory and X-Ray Services \$150 aggregate benefit aboratory and X-Ray Services)   Uther than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value ab and x-Ray: (when no fracture is demonstrated)   veditional Services 100% UCR 100% UCR 100% UCR   umbulance Transportation: (Ground Only) \$300 Maximum \$500 Maximum 100% UCR   verteer Nurse: 100% UCR 100% UCR 100% UCR 100% UCR   umbulance Transportation: (Ground Only) <t< td=""><td>Daily Room &amp; Board: Semi Private Room</td><td>\$300 per day</td></t<>	Daily Room & Board: Semi Private Room	\$300 per day
imergency Room Charges: When hospital confinement is not required \$400 Maximum   imergency Room Charges: If out-patient surgery is required, the maximum is \$1,500 Maximum   increased to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.) \$1,500 Maximum   thysician Services 40% of the Surgery Benefit Paid   urgery: including pre- and post-operative care* \$170 Unit Value   Ansethesia: 40% of the Surgery Benefit Paid   boctor's Visit: other than for Physiotherapy or similar treatment not payable in 100% UCR   iddition to Surgery Benefit \$100 moty UCR   kon-Surgical doctor's charges in the emergency room \$70 per visit   econd Surgical Opinion, Consultation and Specialists \$150 aggregate benefit   aboratory and X-Ray Services 200 Unit Value   Other than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   viditional Services 100% UCR   thysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anipulation, Massage and Heat Maximum of \$500   tegistered Nurse: 100% UCR 100% UCR   windulater Transportation: (Ground Only) \$3300 Maximum \$200 per tooth <td>Miscellaneous Hospital Services: During hospital confinement</td> <td>\$3,000</td>	Miscellaneous Hospital Services: During hospital confinement	\$3,000
imergency Room Charges: If out-patient surgery is required, the maximum is ncreased to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.) thysician Services\$1,500 Maximumwrgery: including pre- and post-operative care*\$170 Unit Valuewrgery: including pre- and post-operative care*\$170 Unit Valuewrgery: including pre- and post-operative care*40% of the Surgery Benefit Paidboctor's Visit: other than for Physiotherapy or similar treatment not payable in didition to Surgery Benefit100% UCRkon-Surgical doctor's charges in the emergency room\$70 per visitbecomd Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray Services\$20 Unit ValueOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 Maximumviditional Services100% UCRbegistered Nurse:100% UCRmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by rrescription\$200 per toothPatal (Including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothyeglasses, Contart Lenses: Replacement of broken glasses and/or frames, contact ense, resulting from a covered injury\$2,500	Intensive Care: When confined to a Hospital Intensive Care Unit	· · · · · · · · · · · · · · · · · · ·
Increased to (The benefits are payable in addition to the X-rays and surgeon's ervices shown below.)\$1,500 Maximumhysician Services\$170 Unit Valueurgery: including pre- and post-operative care*\$170 Unit Valueurgery: including pre- and post-operative care*40% of the Surgery Benefit PaidNuesthesia:40% of the Surgery Benefit PaidNor-Surgical doctor's Visit: other than for Physiotherapy or similar treatment not payable in ddition to Surgery Benefit100% UCRNon-Surgical doctor's charges in the emergency room\$70 per visiteecond Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray Services\$200 Unit ValueOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services100% UCR"hysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Alanipulation, Massage and HeatMaximum of \$500tegistered Nurse:100% UCRwrbulance Transportation: (Ground Only)\$300 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by rescription\$200 per toothDut-Patient Sound and natural at the time of injury veglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$200 per toothweddetional Death Benefit\$2,500	Emergency Room Charges: When hospital confinement is not required	\$400 Maximum
urgery: including pre- and post-operative care*\$170 Unit Valueunesthesia:40% of the Surgery Benefit Paidussistant Surgeon:40% of the Surgery Benefit Paidboctor's Visit: other than for Physiotherapy or similar treatment not payable in didition to Surgery Benefit100% UCRlon-Surgical doctor's charges in the emergency room\$70 per visitecond Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray Services20 Unit ValueOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 Maximumvdditional Services500/Treatmentthysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anaipulation, Massage and Heat\$50/Treatmenttopschered Nurse:100% UCROrthopedic Appliances: When ordered by attending physician\$500 MaximumOut-Patient Drugs and Medication: Administered in Doctor's office or by mescription\$200 per toothDetatal (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothtygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$200 per toothtygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$200tygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$200	<b>Emergency Room Charges:</b> If out-patient surgery is required, the maximum is increased to (The benefits are payable in addition to the X-rays and surgeon's services shown below.)	\$1,500 Maximum
Anesthesia:40% of the Surgery Benefit PaidAssistant Surgeon:40% of the Surgery Benefit PaidJoctor's Visit: other than for Physiotherapy or similar treatment not payable in ddition to Surgery Benefit100% UCRJon-Surgical doctor's charges in the emergency room\$70 per visiteecond Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray Services200 Unit ValueOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services400% UCR"hysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anaipulation, Massage and HeatMaximum of \$500tegistered Nurse:100% UCRwmbulance Transportation: (Ground Only)\$300 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by prescription\$200 per toothSurgerses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$100 maximumAucidental Death Benefit\$2,500	Physician Services	
Assistant Surgeon:40% of the Surgery Benefit PaidDoctor's Visit: other than for Physiotherapy or similar treatment not payable in iddition to Surgery Benefit100% UCRJon-Surgical doctor's charges in the emergency room\$70 per visitecond Surgical doctor's charges in the emergency room\$150 aggregate benefitaboratory and X-Ray Services\$20 Unit ValueOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services\$20/TreatmentPhysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anaipulation, Massage and HeatMaximum of \$50/TreatmentMusimulation, Massage and Heat100% UCRStop Patient Drugs and Medication: Administered in Doctor's office or by orrescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothSyselses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$200 per toothAucidental Death Benefit\$2,500	Surgery: including pre- and post-operative care*	\$170 Unit Value
Dector's Visit: other than for Physiotherapy or similar treatment not payable in Iddition to Surgery Benefit100% UCRJon-Surgical doctor's charges in the emergency room\$70 per visitJecond Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray Services*********************************	Anesthesia:	40% of the Surgery Benefit Paid
Iddition to Surgery Benefit Iddition to Surgery Benefit   Non-Surgical doctor's charges in the emergency room \$70 per visit   iecond Surgical Opinion, Consultation and Specialists \$150 aggregate benefit   aboratory and X-Ray Services 20 Unit Value   Other than Dental and including fee for interpretation and/or reading of X-rays.)* \$20 Unit Value   ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   Additional Services 4400 Maximum   Hysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, \$50/Treatment   Manipulation, Massage and Heat 100% UCR   tegistered Nurse: 100% UCR   Winbulance Transportation: (Ground Only) \$300 Maximum   Dut-Patient Drugs and Medication: Administered in Doctor's office or by 100% UCR   rescription \$200 per tooth   Ooth which was sound and natural at the time of injury \$200 per tooth   Stygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact \$100 maximum   enses, resulting from a covered injury \$2,500	Assistant Surgeon:	40% of the Surgery Benefit Paid
Non-Surgical doctor's charges in the emergency room\$70 per visitdecond Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray ServicesOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services"hysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat\$50/Treatment Maximum of \$500Registered Nurse:100% UCRwmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by prescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothStygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500	<b>Doctor's Visit:</b> other than for Physiotherapy or similar treatment not payable in addition to Surgery Benefit	100% UCR
Account Surgical Opinion, Consultation and Specialists\$150 aggregate benefitaboratory and X-Ray ServicesOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services\$50/TreatmentPhysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Anaipulation, Massage and Heat\$50/TreatmentMaximum of \$500100% UCRRegistered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by orescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothSyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500		\$70 per visit
aboratory and X-Ray ServicesOther than Dental and including fee for interpretation and/or reading of X-rays.)*\$20 Unit Valueab and X-Ray: (when no fracture is demonstrated)\$400 MaximumAdditional Services\$50/TreatmentPhysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat\$50/Treatment Maximum of \$500Registered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumDut-Patient Drugs and Medication: Administered in Doctor's office or by orescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothStygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500		
ab and X-Ray: (when no fracture is demonstrated) \$400 Maximum   Additional Services \$50/Treatment   Physiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Maximum of \$500   Annipulation, Massage and Heat Maximum of \$500   Registered Nurse: 100% UCR   Ambulance Transportation: (Ground Only) \$300 Maximum   Orthopedic Appliances: When ordered by attending physician \$500 Maximum   Dut-Patient Drugs and Medication: Administered in Doctor's office or by orescription 100% UCR   Dental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury \$200 per tooth   Styeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury \$2,500	Laboratory and X-Ray Services	
Additional ServicesPhysiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat\$50/Treatment Maximum of \$500Registered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumOut-Patient Drugs and Medication: Administered in Doctor's office or by orescription100% UCROpental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothSyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$100 maximumSuccidental Death Benefit\$2,500	(Other than Dental and including fee for interpretation and/or reading of X-rays.)*	\$20 Unit Value
Physiotherapy or similar treatment: including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat\$50/Treatment Maximum of \$500Anipulation, Massage and Heat100% UCRRegistered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumOut-Patient Drugs and Medication: Administered in Doctor's office or by orescription100% UCROpental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothSyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500	Lab and X-Ray: (when no fracture is demonstrated)	\$400 Maximum
Manipulation, Massage and HeatMaximum of \$500Registered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumOut-Patient Drugs and Medication: Administered in Doctor's office or by prescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothStygelasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500	Additional Services	
Registered Nurse:100% UCRAmbulance Transportation: (Ground Only)\$300 MaximumOrthopedic Appliances: When ordered by attending physician\$500 MaximumOut-Patient Drugs and Medication: Administered in Doctor's office or by orescription100% UCRDental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury\$200 per toothStyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury\$2,500	<b>Physiotherapy or similar treatment:</b> including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat	
Ambulance Transportation: (Ground Only) \$300 Maximum   Orthopedic Appliances: When ordered by attending physician \$500 Maximum   Out-Patient Drugs and Medication: Administered in Doctor's office or by prescription 100% UCR   Oental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury \$200 per tooth   Syeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury \$100 maximum   Accidental Death Benefit \$2,500		
Orthopedic Appliances: When ordered by attending physician \$500 Maximum   Out-Patient Drugs and Medication: Administered in Doctor's office or by prescription 100% UCR   Dental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury \$200 per tooth   Syeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury \$100 maximum   Accidental Death Benefit \$2,500	-	
Dut-Patient Drugs and Medication: Administered in Doctor's office or by 100% UCR   Dental (including X-rays): For treatment, repair or replacement of each injured \$200 per tooth   ooth which was sound and natural at the time of injury \$200 per tooth   Syeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact \$100 maximum   Accidental Death Benefit \$2,500		-
Dental (including X-rays): For treatment, repair or replacement of each injured ooth which was sound and natural at the time of injury \$200 per tooth   Syeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury \$100 maximum   Accidental Death Benefit \$2,500	Out-Patient Drugs and Medication: Administered in Doctor's office or by	100% UCR
Syeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact \$100 maximum   enses, resulting from a covered injury \$2,500	<b>Dental (including X-rays):</b> For treatment, repair or replacement of each injured tooth which was sound and natural at the time of injury	\$200 per tooth
	Eyeglasses, Contact Lenses: Replacement of broken glasses and/or frames, contact enses, resulting from a covered injury	\$100 maximum
	Assidental Death Reposit	¢2 500
	Accidental Death Benefit Accidental Dismemberment, Loss of Sight	\$2,500

## **Policy 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. (In Missouri this applies only while sane.);
  - (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. 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
      - 1) Within 24 hours of the start of the release.

#### Benefits will not be paid for:

- 1. Normal health check ups
- 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 Certificateholder; 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 ultra light, 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
  - a. Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
- 10. Any sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food;
- 11. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;
- 12. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Certificate;
- 13. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
- 14. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
- 15. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
- 16. 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;
- 17. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
- 18. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
- 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. Services and supplies furnished by a Student Infirmary, its employees, or doctors who work for the School;
- 25. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits; or
- 26. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound.
- 27. Rest cures or custodial care;
- 28. Prescription medicines unless specifically provided for under the Certificate:
- 29. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;

## How to Enroll

- 1. Determine which plan of coverage you would like to enroll your child in 24 Hour Coverage or School Time Coverage
- Fill out the Enrollment Form below, enclose a check or money order in an envelope payable to the Company for the correct amount and mail to A-G Administrators LLC PO Box 824936 Lock Box # 824936 Philadelphia, PA 19182-4936
- 3. Make Checks Payable to UNITED STATES FIRE INSURANCE COMPANY c/o A-G Administrators LLC
- 4. Return by mail to A-G Administrators LLC. Your cancelled check or money order stub will be your receipt and confirmation of payment. Please write student's name and school name on your check).

STUDENT'S LAST NAME (one letter per box)	
STUDENTS FIRST NAME	Individual Voluntary Student Accident Plans
Age: Grade: Phone #:	24-HOUR COVERAGE
Date of Birth: Gender: Male 🗆 Female 🗆	\$90.00 per student per year
Home Address	SCHOOL TIME COVERAGE
City State Zip	\$22.50 per student
Name of School	
School District	

## **Period of Coverage**

Persons applying for coverage shall be covered as of the date premium receipt, but in no event prior to the opening of school activities. Coverage ends at the close of the regular school term, except under 24-Hour Coverage, which continues until school reopens for the fall term. You may enroll at any time, but premiums will not be prorated.

#### Q. Is this Policy primary or secondary coverage?

A. This policy is Primary – meaning A-G will pay valid medical expenses payable without regard to any other valid and collectible insurance plan.

#### Q. May we purchase the policy at any time during the year?

A. Yes, coverage may be purchased at any point in time during the school year for your child. However, there is no pro-rating of premium for enrollment that occurs after the policy effective date. The earlier you enroll the more your child will maximize their coverage.

#### Q. Will this policy pay if our other insurance has a deductible?

A. Yes, benefits are paid without regard to other insurance.

## How to File a Claim

- 1. Obtain an accident claim form through your school office or A-G Administrators LLC. Please answer all questions and provide all necessary signatures.
- 2. Attach all itemized bill(s) and any explanation of benefits to the claim form and mail or fax to the Administrator's Address indicated on the claim form.
- **3**. Claims for benefits must be filed within 90 days from the date of accident. Only one claim form is needed per accident.

### **Important Note**

This brochure is a summary of the insurance plan as specified in the policy form (BA-50000P-USF) on file with the School. This brochure is subject to the terms and conditions of the Policy, which contains all benefits, limitations and exclusions as underwritten by United States Fire Insurance Company. This coverage may not be available in all states and Policy terms and conditions may vary by state. In the event of a discrepancy, the Policy with prevail.