

Voluntary Student Accident Medical Insurance

**K-12 Schools
2024-25**



**STUDENT
INSURANCE**

A VENBROOK COMPANY

SIRep@studentinsuranceusa.com
Lic #0386216



Accidents aren't supposed to happen, but they do.

School recess, one-day field trips and general day-to-day activities can all lead to injuries. Having coverage during school hours, or around the clock can insure your loved ones get the care they need without financial hardship to your family.

ELIGIBILITY

Any enrolled student is eligible for coverage.

12 ACCIDENT PLANS THAT ARE AVAILABLE THROUGH YOUR SCHOOL:

- School Time Accident Only
- 24-Hour Accident Only
- Optional Football Coverage
- 24-Hour Dental

All available plans are offered by Special Markets Insurance Consultants, Inc. To research which plans are being offered by your school, please visit our website's online enrollment tool at www.studentinsuranceusa.com

PAYMENT

Parents or guardians of students are responsible for enrollment and premium payment.

HOW TO ENROLL

Enrolling is easy and only takes a few minutes.

Go to <https://studentinsuranceusa.com/insurance/k-12-student-accident-insurance-plan-enrollment/>

1. Go to Online Enrollment
2. Click on School or District
3. Select Coverage

Parents can either print or complete the enrollment application to mail with check or money order or:

You can enroll online:

1. Enroll online by clicking "Enroll Now"
2. Select State and click "Look Up"
3. Click on School or District
4. Select school location name (if applicable)
5. Check the plan options
6. Complete online application (more than one child can be enrolled on the same application)
7. Pay by credit/debit
8. Print ID card

About Student Insurance

Since 1950 Student Insurance, Inc. (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. For further details of the coverage outlined above, including costs, benefits, exclusions and any reductions or limitation, and the terms under which the policy may be continued in force, please refer to www.studentinsuranceusa.com. Students are able to purchase coverage only if his/her school district is a policyholder with the insurance company.

2024-2025 STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.

Annual Premium: Plan "Low" – \$14.00 Plan "Medium" – \$28.00 Plan "High" – \$43.00

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).

Annual Premium: Plan "Low" – \$82.00 Plan "Medium" – \$105.00 Plan "High" – \$210.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterrupted to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.

Annual Premium: Plan "Low" – \$85.00 Plan "Medium" – \$115.00 Plan "High" – \$215.00

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is \$25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of \$1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: \$8.00**

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted (**no pro rata premiums available**).

SCHEDULE OF BENEFITS			
Coverage for Injuries due to Accidents only			
Maximum Benefit:	Plan "Low"	Plan "Medium"	Plan "High"
School-Time Option	\$25,000	\$50,000	\$100,000
24-Hour Option	\$25,000	\$50,000	\$100,000
Football Option	\$25,000	\$50,000	\$100,000
Injuries Involving Motor Vehicles	\$10,000	\$10,000	\$ 10,000
Death Benefit/Double Dismemberment	\$10,000	\$20,000	\$ 20,000
Single Dismemberment	\$ 5,000	\$10,000	\$ 10,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D/Loss of Sight Benefits	1 Year	1 Year	1 Year
Excess Coverage Applicability	Full Excess	Full Excess	Full Excess
Hospital/Facility Services - Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	65% RE*	75% RE*	80% RE*
Inpatient Hospital Miscellaneous	65% RE*	75% RE*	80% RE*
Hospital/Facility Services - Outpatient			
Free-Standing Ambulatory Surgical Facility	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Hospital Emergency Room	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Physician's Services			
Surgical	65% RE*	75% RE*	80% RE*
Assistant Surgeon	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	65% RE* / \$25 Visit/5 Visit Max.	75% RE* / \$30 Visit/7 Visit Max.	80% RE* / \$40 Visit/8 Visit Max.
Physician's Non-surgical Treatment (Except as above)	65% RE*	75% RE*	80% RE*
Other Services			
Registered Nurses' Services	65% RE*	75% RE*	80% RE*
Prescriptions - outpatient	65% RE*	75% RE*	80% RE*
Laboratory Tests – Outpatient	65% RE*	75% RE*	80% RE*
X-rays, includes interpretation – Outpatient	65% RE*	75% RE*	80% RE*
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	65% RE*	75% RE*	80% RE*
Ground Ambulance	65% RE*	75% RE*	80% RE*
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	65% RE*	75% RE*	80% RE*
Dental Treatment to sound, natural teeth due to covered injury	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	\$150 Maximum	\$500 Maximum	\$700 Maximum
*RE means Reasonable Expense			GER_0418 EFTB(0009)

2024 – 2025 ENROLLMENT APPLICATION (please print or type)

Student's Last Name _____ Student's First Name _____ Student's Middle Initial _____ Grade _____
 Address _____ City _____ State _____ Zip _____
 Telephone Number _____ Birthdate _____
 School System _____ Name of School _____

Check your selection:

Plan "Low" School-Time \$14.00 24-Hour Accident \$ 82.00 Football \$ 85.00 24-Hour Dental \$8.00
 Plan "Medium" School-Time \$28.00 24-Hour Accident \$105.00 Football \$115.00 24-Hour Dental \$8.00
 Plan "High" School-Time \$43.00 24-Hour Accident \$210.00 Football \$215.00 24-Hour Dental \$8.00

Please make check payable to Gerber Life Insurance Company

Signature of Parent or Guardian _____ Date _____ Total Enclosed: _____



CLAIM FORM

SIGNED CLAIM FORM IS REQUIRED

- 1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com

IMPORTANT NOTICE:

Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: The accident policy benefits are limited and may not provide 100% coverage.

< IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED >

PART 1-A - TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name Policy Number
School/Team/League Name Phone No. ()
Address Email
Type of Activity/Sport

If Athletics, designate P.E. Class Intramural Interscholastic Intercollegiate Game Jr. Varsity Varsity
Youth Adult Practice Other

Name of injured person/student

Date of Accident Accident Time

Date of First Treatment Has treatment been completed? Yes No

Where and how did accident occur? (Please be specific)

Part of body Injured Right or Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? Yes No

Under whose supervision? Was he/she a witness? Yes No

Authorized Signature Title Date

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B - TO BE COMPLETED IN FULL BY CLAIMANT - OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name Preferred/Nickname:

Date of Birth Age Grade Level Male Female

Claimant is a Student Player Coach Official/Umpire Volunteer Child Care Participant CE Student (# of credits)

Address of Injured Person or Parents/Guardian

Phone No. () Email Address

If Injured party is over age 18: Employer Name and Address

Phone No. () Self Employed Unemployed

Father/Guardian Name

Employer Name and Address Phone No. ()

Self Employed Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name _____

Employer Name and Address _____ Phone No. () _____

Self Employed Unemployed

Is claimant covered under any other medical and or dental insurance policy? Yes No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? Yes No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	Address	Policy #

Are benefits due for this claim under these other insurance coverages? Yes No (See **IMPORTANT NOTICE** at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? Yes No If yes, please give name, address and phone number of responsible party _____

AFFIDAVIT: I verify that the above 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 it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian _____ Date: _____

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian _____ Date: _____

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

◆ Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

◆ If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

◆ If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

◆ Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

◆ If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

◆ Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

SAMPLE HCFA 1500

SAMPLE UB-04

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED ONE-0008-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SMA/MA) OTHER 14 INSURER'S ID NUMBER (FOR PROGRAM INTERVIEW)

2. PATIENT'S NAME (Last, First, Middle Initial) 3. PATIENT'S BIRTH DATE (MM / DD / YY) 4. INSURER'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT'S RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURER'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Include Area Code) 9. INSURER'S CITY STATE ZIP CODE TELEPHONE (Include Area Code)

10. OTHER INSURERS' POLICY OR GROUP NUMBER 11. EMPLOYMENT (Current or Previous) 12. EMPLOYER'S NAME OR SCHOOL NAME 13. INSURANCE PLAN NAME OR PROGRAM NAME

14. DATE OF CURRENT ILLNESS (MM / DD / YY) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (Give First Date: MM / DD / YY) 16. DATE (PERIOD) UNABLE TO WORK IN CURRENT OCCUPATION (FROM: MM / DD / YY TO: MM / DD / YY)

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 18. TO NUMBER OF REFERRING PHYSICIAN 19. HOSPITALIZATION/DAYS REQUIRED TO CURRENT SERVICE (FROM: MM / DD / YY TO: MM / DD / YY)

20. OUTSIDE LAMP 21. CHARGES 22. MEDICAL RELEASER'S SIGNATURE ORIGINAL REF NO. CODE 23. PRIOR AUTHORIZATION NUMBER

24. ADDRESS OF SERVICE (City, State, Zip) 25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES/NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include Denial or Credit Status) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

APPROVED BY AAA COUNCIL ON MEDICAL SERVICE 9/93 PLEASE PRINT OR TYPE FORM HCFA 1500 (10-03) FORM 980-1500 FORM OMBP-1002

UB-04

1. PATIENT INFORMATION

2. PROVIDER INFORMATION

3. SERVICE INFORMATION

4. CHARGE INFORMATION

5. PAYMENT INFORMATION

6. OTHER INFORMATION

PAGE GR CREATION DATE TOTALS

SAMPLE EOB (EXPLANATION OF BENEFITS)

UnitedHealthcare
A UnitedHealth Group Company

UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-636-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

PATIENT/RELAT CLAIM NUMBER	PROVIDER/SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061912101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94	4C
		TOTAL	379.00	297.83	81.17			64.94	
								MEDICARE PAID 44.64 PLAN PAYS 20.30	

1-1- INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
14C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

\$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY	\$1000.00	\$1328.77
INDV	\$500.00	\$1281.45
PLAN YEAR 2010	FAMILY \$1000.00	FAMILY \$8000.00
	INDV \$500.00	INDV \$4000.00