AUBURN • CHARLTON • DUDLEY • NORTH BROOKFIELD • OXFORD • PAXTON
RUTLAND • SOUTHBRIDGE • SPENCER • WEBSTER
Southern Worcester County Regional Vocational School District
BAY PATH REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
57 OLD MUGGETT HILL ROAD
CHARLTON, MASSACHUSETTS 01507-1331
(508) 248-5971 - (508) 987-0326
FAX (508) 248-4747

August 28, 2018

Dear Parents/Guardians:

For this school year, 2018-2019, the Southern Worcester County Regional Vocational School Committee has purchased school time coverage from the Bob McCloskey Insurance Agency. This coverage is **SECONDARY INSURANCE**. This means, if you have any other medical insurance, you are required to file a claim with your medical insurance **FIRST**, and only that portion not covered by your medical insurance will be picked up by the Bob McCloskey Insurance Agency, if it is covered by their guidelines. **This is a Limited Benefit Policy, not all expenses may be covered under this insurance. Please see the Summary of Benefits and Limitations for policy limits.**

I have enclosed a brochure which you may use if you wish to purchase 24-hour coverage online at www.bobmccloskey.com for a $49 premium, or the dental **accident** plan for a $10.00 premium. I have also included a copy of the online enrollment form for those who might not have the ability to make an online payment.

Please let me remind you of the fact that your other medical insurance will be the primary source of coverage. Only that which is **not** covered by your insurance may be picked up by the Bob McCloskey Insurance Agency, **with the certain limitations illustrated in your Summary of Benefits and Limitations.**

If you should have any questions regarding filling out this form, please feel free to contact my office between 7:00 a.m. and 3:00 p.m. at the school, at 508 248-5971 or 508 987-0326, Extension 1754.

Sincerely,

Kristin Surozenski
Financial Assistant

Enclosure

Accident Insurance Protection for Students

Parents and Guardians: Do you have adequate insurance coverage for your child in the event of an unforeseen accident?

Bob McCloskey Insurance has got you covered!

Depending on which program your child's school offers, you may be able to purchase one or more of the following insurance products on a voluntary basis ...

- ✓ $500,000 At School Student Accident Coverage
- ✓ $500,000 Around the Clock – 24 Hour Accident Coverage
- ✓ $50,000 Student Accident Dental Coverage

... with relative ease from any computer or ipad via the following online address:

www.bobmccloskey.com

Just follow the instructions and you can accomplish the process in minutes. And, should you have any questions, you can call

1-800-445-3126

and a representative will be happy to assist you with the process or any questions.

Bob McCloskey Insurance
P.O. Box 511 Matawan, NJ 07747
www.bobmccloskey.com

Got You Covered

SUMMARY OF BENEFITS AND LIMITATIONS

The Policy provides benefits for a loss due to a covered injury as defined in the Policy up to a maximum benefit as described below for each injury. The coverage would be for those medical/dental expenses incurred within 104 weeks from the date of the original Accident. Treatment must begin within 60 days from the date of the Accident by a legally licensed medical or dental practitioner (not a member of the Insured's immediate family).

An Accident is defined in the policy as a sudden, unexpected event that results in Injury to the Covered Person.

ACCIDENTAL MEDICAL AND DENTAL EXPENSE BENEFITS

Maximum Accident Medical Policy Limit	$500,000
Motor Vehicle Accidents	$10,000 maximum
Hospital room and board expenses	$500 per day
Daily Intensive Care Unit/ Cardiac Care Unit Expenses	$1,000 per day up to 5 days
Ancillary Hospital expenses	$500 maximum
Physician non-surgical (inpatient)	Usual & Customary Charges
Physician surgical expenses	Usual & Customary
Assistant Surgeon expenses	25% of Physician surgical
Anesthesiologist expenses	25% of Physician surgical benefit
Outpatient surgery expenses	$500 maximum
Physician non-surgical (outpatient)	Usual & Customary Charges
Physician Consultant Expense (outpatient)	Usual & Customary Charges
Physiotherapy (outpatient)	Usual & Customary up to a maximum of $2,000
Ambulance expenses	Usual & Customary Charges
X-ray expenses (outpatient)	Usual & Customary Charges
Outpatient laboratory test expenses	Usual & Customary Charges
Diagnostic imaging expenses	$500
Medical Emergency Care	$500
Prescription drug expenses	Usual & Customary Charges
Outpatient registered nurse services	Usual & Customary Charges
Rehabilitative braces or appliances	$2,000 maximum
Dental expenses	$500 per tooth maximum
Deferred Dental Treatment (when certified by a dentist)	$1,000
Eyeglasses, contact lenses and hearing aids	$500 maximum

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, within 365 days from the date of a Covered Accident, Injury to the Covered Person results in any of the Covered Losses shown below, We will pay the benefit in the amount set opposite such Loss, as shown on the Schedule of Benefits. If multiple Losses occur, only one Benefit, the largest, will be paid for all Losses due to the same Covered Accident.

Loss of Life	$10,000
Loss of Two or More Members	$50,000
Loss of One Member	$25,000
Loss of Thumb & Index Finger of the Same Hand	$2,500
Loss of Four Fingers of the Same Hand	$2,500

DEFINITIONS

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

INJURY means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose Injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

IMPORTANT FACTS

1. This is a **Limited Benefit Policy**
2. The Blanket Accident Policy on file with the school is a non-renewable, one-year term policy.
3. **EFFECTIVE DATE OF COVERAGE:** Insurance is effective on the latest of the following dates:
   - the Policy Effective Date;
   - the date the Covered Person is first eligible;
   - the date We receive the completed enrollment form; or
   - the date the required premium is paid.
4. **EVIDENCE OF COVERAGE:** Verification of online payment and a copy of this brochure is your evidence of coverage under the School Sponsored Accident Policy.
5. **STUDENT TRANSFER:** Coverage under the Policy continues in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.
6. **CANCELLATION:** Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
7. **LATE ENROLLMENT:** There is no premium reduction for any individual who enrolls late in the year.

EXCESS PROVISION

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor, Benefit Period, and Co-payment shown on the Schedule of Benefits that are in EXCESS of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. If no other coverage or plan is available, this program will pay the Covered Medical/ Dental Expenses incurred to the limits stated in the Policy.

PARENTS/GUARDIANS - WHY YOU SHOULD ENROLL NOW

- When a covered accident happens, benefits are paid directly to you – not the hospital or doctor – to use any way you want. Pay for medical bills, groceries, lost time at work – anything.
- Even if you have health insurance, benefits can help cover your deductible, copayment, and other out-of-pocket costs.
- Accident benefits are preset and are paid, regardless of any other insurance you have.
- No health questions asked – everyone qualifies.
- Rates cannot increase during the year.

POLICY EXCLUSIONS

This Policy does not cover any Loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the Loss is an accidental bodily injury, unless otherwise covered under the Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
6. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
7. Participation in any motorized race or speed contest.
8. Aggravation or re-injury of a prior Injury that the Covered Person suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Covered Person's Physician.
9. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling assault or battery.
10. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
11. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
12. Treatment of a hernia whether or not caused by a Covered Accident.
13. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from, except as a fare paying passenger on a regularly scheduled commercial airline.

HOW TO FILE A CLAIM

1. Obtain a claim form from your school office or Bob McCloskey Insurance, (800-445-3126), and answer all questions in detail on the front of the claim form.
2. The claim form should identify the student's name, school name or district, and the date of accident.
3. Make sure the claim form is signed.
4. Attach all itemized bills to the completed claim form and mail to Bob McCloskey Insurance at the address provided on the claim form.
5. Bills that cannot be attached to the initial form must be submitted within **90 days of the date of service.**

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

Claims Administrator:

Bob McCloskey Insurance
P.O. Box 511
Matawan, NJ 07747
Phone: 800-445-3126

MA Compulsory

CHOOSE THE PLAN THAT IS RIGHT FOR YOU!

Annual Cost

A. Around-the-Clock Coverage (Accident Only) **$ 49.00**

Around-the-clock/anywhere in the world 24 hours a day; until one year after the date the Policy coverage begins. Coverage ends when school reopens the following school year. Covers eligible injuries resulting from covered accidents:

- Before, during and after school
- Weekends, vacation and all summer including summer school
- School sponsored and supervised extracurricular activities excluding interscholastic sports

B. Dental Coverage (Accident Only) **$ 10.00**

- Voluntary supplemental dental coverage in effect 24 hours a day extended to students with Around-the-Clock or At-School Coverage.
- Benefits not to exceed a maximum of $50,000 when injury to sound natural teeth requires treatment within 60 days of a covered accident.
- Only eligible expenses incurred by the Covered Person within the Benefit Period from the date of the accident are covered.
- If a dentist certifies that treatment must be deferred, deferred benefits will be paid to a maximum of $1,000.

IMPORTANT: KEEP THIS SUMMARY FOR YOUR PERSONAL RECORDS AS A DESCRIPTION OF COVERAGE.

IMPORTANT: This is a brief description of coverage provided under policy form series AH51051, underwritten by Berkley Life and Health Insurance Company (domiciled in Iowa - California Certificate of Authority #08527) 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690 and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy for complete details.

The insurance described in this document provides limited benefits. Limited benefit plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential coverage as set forth under the Patient Protection and Affordable Care Act.

ENROLLMENT FORM FOR STUDENT ACCIDENT INSURANCE 2018-2019 SCHOOL YEAR

ENROLLMENT INSTRUCTIONS

- Fill out this enrollment form completely.
- Make your check or money order payable to Bob McCloskey Insurance. Be sure to write your child's name on the check. DO NOT send cash.
- Place this form and your payment into an envelope and mail to the address below.
- Keep your cancelled check or money order receipt as proof of payment.
- Keep the summary document in your records as a description of coverage.
- Print and keep the Student Insurance ID Card.

School System: _____

School Name: _____

Student Last Name: _____

Student First Name: _____

Student Date of Birth (mo/day/year) / / Sex: ☐ M ☐ F

Student Home Phone: ( )

Student Address: _____

Street

City State Zip

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PLAN SELECTION

Check one:	Annual Premium
☐ Around-the-Clock Coverage	$ 49.00
☐ Dental Coverage	$ 10.00

Make check or money order payable to:
Bob McCloskey Insurance

Amount Enclosed: _____

Check or money order number: _____

_____

Signature of Parent/Guardian Date

Mail to:
Bob McCloskey Insurance
P.O. Box 511
Matawan, NJ 07747

Insurance Underwritten by Berkley Life and Health Insurance Company
Policy Form Series: AH51051

BAH SR 2018-114EF