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

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

2017-2018
AXIS Insurance Company
24 Hour Accident Coverage
Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. . . . . . . $55.00

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

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. . . . . . . $15.00

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

Direct All Questions and Correspondence To:
LEFEBVRE INSURANCE, LLC
850 Franklin Street, Wrentham, MA 02093
(800) 451-9668

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

Disclosure: US insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. 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 benefits as set for the under the Patient Protection and Affordable Care Act.

Optional $50,000 Extended Dental Benefit
When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury. The insured’s liability will be extended to include dental treatment of a Dental Injury within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means Replacement of caps, crowns, dentures, and orthodontic appliances, 
   (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of injury.

2. In no event shall the Company's payment exceed the Usual & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Covered Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.

3. If the Insured’s Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. . . . . . . $8.00
This coverage cannot be purchased without School Time or 24 Hour coverage.

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

- Life ......................................................... $5,000
   ($15,000 for a death under the Sports Condition of Coverage)
- Both hands or both feet or the entire sight of both eyes ................... $20,000
- One Hand and One Foot .................................. $20,000
- Either One Hand or One Foot and the Entire Sight of One Eye ........ $20,000
- One Hand or One Foot or the entire sight of one eye ................... $10,000

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

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

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

All other coverages end when School begins regularly scheduled classes for the following School term.
ACCIDENT INSURANCE PROTECTION
PROVIDING A MAXIMUM OF $1,000,000 MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a covered injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 104 weeks from the date of the Injury.

MAXIMUM BENEFITS

Hospital Services:
- Daily Room & Board (Semi-private) .......... Up to $800/day
- Intensive Care Room & Board .............. Usual & Customary

Miscellaneous Services:
- During Hospital Confinement or when surgery is performed ........................................ $800/day
- Emergency Room outpatient: when Hospital Confinement is not required .......... Usual & Customary

Doctor's Services:
- Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of ............................................. $150.00/unit value
- Anesthesia (including administration) and assistant surgeon: % of surgical allowance .......... 25%
- Doctor visit other than for physiotherapy or similar treatment when no surgery benefits paid .......... Usual & Customary
- Consultants (when required by attending physician for confirmation or determining a diagnosis, but not for treatment) and second opinion ........................................ Usual & Customary

Laboratory & X-Ray Services:
- Other than Dental and including fee for interpretation and/or reading of X-Ray
- X-ray when not Hospital Confining X-Ray .......... Usual & Customary
- Lab ................................................ Usual & Customary
- MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading ........................................ $800.00

Additional Services:
- Physiotherapy or similar treatment:
  - In-Hospital ....................................... Usual & Customary
  - Out of Hospital ............................... $1,500.00
- Chiropractic Services (in or out of hospital) .............. $500.00
- Registered Nurse (in or out of hospital) .............. Usual & Customary
- Ambulance to initial treatment facility .............. Usual & Customary
- Orthopedic Appliances:
  - In-hospital ....................................... Usual & Customary
  - Out of hospital ............................... $1,000.00
- Out patient drugs & medication
  - Administered by a Doctor .......................... Usual & Customary
- Eyeglasses, contact lenses and hearing aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered injury ........................................ $650.00

Dental Services:
- For treatment, repair or replacement of injured natural teeth, includes initial braces when required for treatment of a covered injury, as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma ........................................ $750/tooth

PRIMARY COVERAGE
Benefits are payable for covered medical expenses from the first dollar, no deductible, no coinsurance, paying in addition and without regard to payments by other insurance up to maximums stated herein. Benefits are payable for a maximum of 104 weeks.

EXCLUSIONS AND LIMITATIONS
Exclusions: The policy does not cover any loss incurred as a result of:

Limitation for Motor Vehicle Accidents
Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Limit shown in the Schedule of Benefits. In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

- intentional self-inflicted injury, suicide, or any attempt while sane or insane;
- commission or attempt to commit a felony or an assault;
- declared or un declared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
- flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
- parachuting;
- Travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound, Accidental ingestion of contaminated food, or purposeful ingestion of controlled drugs;
- a cardiovascular, event or stroke resulting, directly and independently of all other causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application);
- voluntary use of any controlled substance as defined in title II of the Comprehensive Drug Abuse Prevention and control Act of 1970, as now or hereafter amended; unless as prescribed by his Physician for the Insured Person;
- injuries compensable under Workers' Compensation law or any similar law, except where an employee is a corporate officer and where a sole proprietor or business partner is not covered by the provisions of chapter 568;
- practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including travelling to and from games and practice, unless specifically provided for in the Master Insurance Application;
- participation in any sport activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal School hours, including snowboarding, skiing and ice hockey;
- benefits will not be paid for services or treatment rendered by any person who is:
  - a. employed or retained by the Policyholder;
  - b. living in the Insured Person's household;
  - c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
  - d. the Insured Person.
To File A Claim:

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

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

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

ENROLLMENT FORM CHECKLIST

Did You:

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

For questions, inquiries, and information contact:

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

Please Print

2017-2018

Make checks payable to:
AXIS Insurance Company

No obligation to purchase.

School Year Rate – 2017-2018

<table>
<thead>
<tr>
<th>Coverage Plans</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour – Including Extended Dental</td>
<td>$63.00</td>
</tr>
<tr>
<td>24 Hour Only</td>
<td>$55.00</td>
</tr>
<tr>
<td>School Time Only – Including Extended Dental</td>
<td>$23.00</td>
</tr>
<tr>
<td>School Time Only</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

How to Enroll

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

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

**MCA Administrators, Inc.**
PO Box 6540
Harrisburg, PA 17112

**CLAIM ASSISTANCE:**
(800) 427-9308

UNDERWRITTEN BY: AXIS INSURANCE COMPANY

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

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

### PART A. POLICY HOLDER

<table>
<thead>
<tr>
<th>(1) Name of School District/College/Organization</th>
<th>Individual School/Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) County</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Address of School: (Street)</th>
<th>(4) ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>(City)</td>
<td></td>
</tr>
<tr>
<td>(State)</td>
<td></td>
</tr>
<tr>
<td>(Area Code - Telephone #)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(5) Date of Injury</th>
<th>(6) Name of Injured Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO/DA/VR</td>
<td></td>
</tr>
<tr>
<td>(7) Date of Birth</td>
<td></td>
</tr>
<tr>
<td>MO/DA/VR</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(8) Social Security #</th>
<th>(9) Age</th>
<th>(10) Grade</th>
<th>(11) MALE/FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>(12) Injury occurred:</th>
<th>(13) Type of Sport:</th>
<th>(14) Describe in detail how the injury occurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice O</td>
<td>At Home O</td>
<td></td>
</tr>
<tr>
<td>Game O</td>
<td>Intramural O</td>
<td></td>
</tr>
<tr>
<td>P.E. O</td>
<td>Interscholastic O</td>
<td></td>
</tr>
<tr>
<td>Travel O</td>
<td>Intercollegiate O</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(15) What part of the body was injured:</th>
<th>(15a) Time of injury:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left or Right side if applicable</td>
<td>a.m. : p.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder?</th>
<th>(18) Was he/she a witness to accident?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes O No</td>
<td>Yes O No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(17) Name of Supervisor (If different from organization official)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(19) Signature of School or Organization Official</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(20) Title of Official</th>
</tr>
</thead>
<tbody>
<tr>
<td>(21) Date Signed</td>
</tr>
</tbody>
</table>

### PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

<table>
<thead>
<tr>
<th>(1) Name of Mother/Father or Guardian</th>
<th>(2) Social Security #</th>
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<tbody>
<tr>
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<td></td>
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<table>
<thead>
<tr>
<th>(3) Relationship to insured:</th>
<th>(4) Address of Number</th>
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</thead>
<tbody>
<tr>
<td>Father O Mother O Guardian O Self</td>
<td>Street (Lot or Apt. No)</td>
</tr>
<tr>
<td></td>
<td>(5) City</td>
</tr>
<tr>
<td></td>
<td>(6) State</td>
</tr>
<tr>
<td></td>
<td>(7) Zip Code</td>
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</tbody>
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<table>
<thead>
<tr>
<th>(8) Area Code - Home Telephone Number</th>
</tr>
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<tbody>
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</table>

| (9) Father's work telephone ( ) |
| (10) Occupation of Father or Mother, Wife or Husband |
| (11) Race of Employment |
| (12) Address of Employer |

| (13) Occupation of Self (If over age 18) |
| (14) Race of Employment |
| (15) Address of Employer |

<table>
<thead>
<tr>
<th>(16) Do you have any other health and/or accident insurance plan (other than this plan)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father: O YES O NO</td>
</tr>
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<table>
<thead>
<tr>
<th>(17) Is the injured person covered by other health and/or accident insurance plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>O YES O NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(18) Name of other health and accident insurance company</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>(19) Address of Insurance Company</th>
<th>(20) Policy Number</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(21) Date Signed</th>
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</thead>
</table>

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

**AUTHORIZED AND ASSIGNMENT OF BENEFITS**

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

Signature of Insured or Authorized Representative

Dated

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER:** I authorize payment of medical payments to the insurance company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefits under the policy number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the insurance company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the policy identified above and that a copy of this Authorization shall be considered as valid as the original. I agree that a photographic copy of this authorization shall be valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I understand that the policyholder, employer or benefit plan administrator may revoke this authorization at any time by providing the insurance company with written notification and a statement of reasons.

Signature of Insured or Authorized Representative

Dated

**ADDRESS**

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

**DATE**

**SIGNATURE OF RESPONSIBLE PARTY OR STUDENT IF 18 YEARS OLD**

**FRAUD WARNING:** "It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."
CLAIM PROCEDURES

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

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

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

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

FRAUD WARNING

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

THINGS TO REMEMBER

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

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

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

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

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

IMPORTANT NOTICE
This Brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in Connecticut under form number BACC-001-0909. Complete details are found in the policy on file at your school’s office. The policy is subject to the laws of the state in which it was issued. Please keep this information for your reference.