ALIVE RISK
A DIVISION OF ALL RISKS, LTD.

2021 VOLUNTARY STUDENT ACCIDENT MEDICAL PLANS

ELIGIBILITY: All Students of the Policyholder

TYPE OF COVERAGE: Voluntary Full Excess Accident Medical

Benefits are payable to the applicable maximum for Covered Accident Medical expenses that are not recoverable from another Plan providing accident medical expense benefits. If the insured person is not covered by another Plan, these benefits are payable as primary benefits up to the limits described in the Benefit Schedule, for the Plan purchased.

PLAN DESCRIPTIONS & RATES:

SCHOOL TIME COVERAGE:

- School term on school premises while school is in session and during school sponsored and supervised activities on and off premises
- Includes participation in interscholastic sports, excluding any participation in senior high interscholastic football grades 10-12. 9th Grade football is included
- Summer Recreation Activities sponsored and supervised by the school
- Travel to and from school sponsored activities while in a vehicle furnished by the policyholder

Standard Plan: $36.00 **Economy Plan: $28.00** **Budget Plan: $13.00**

FOOTBALL COVERAGE FOR:

- Practice and participation in senior high interscholastic tackle football fall and spring sessions
- Includes coverage for all other sports and school time sponsored and supervised activities as described in the School Time Plan
- Travel to and from school sponsored activities while in a vehicle furnished by the policyholder

Standard Plan: $143.00 **Economy Plan: $99.00** **Budget Plan: $49.00**

SPRING FOOTBALL COVERAGE FOR:

- New players participating in spring training who have not purchased Football Coverage
- Travel to and from school sponsored activities while in a vehicle furnished by the policyholder

Standard Plan: $57.00 **Economy Plan: $39.00** **Budget Plan: $20.00**

24 HOUR COVERAGE FOR:

- 24 hour, 7 days a week coverage with benefits payable up to 12 months from injury date.
- School sponsored and supervised and supervised activities and sports, excluding senior high interscholastic (grades 10-12) football.
- Travel to and from school sponsored activities while in a vehicle furnished by the policyholder

Standard Plan: $85.00 **Economy Plan: $55.00** **Budget Plan: $39.00**

EXTENDED DENTAL:

- Add on coverage when purchasing School Time, 24 Hour or Football Coverage
- Benefits up to a maximum of $10,000

Rate: $7.00

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SCHEDULE OF BENEFITS

Voluntary Plans	Standard	Economy	Budget
Medical Maximum	$25,000	$25,000	$25,000
Deductible	$0	$0	$0
Coverage	Full Excess	Full Excess	Full Excess
Benefit Period	1 Year	1 Year	1 Year
Loss Period	60 days	60 days	60 days
Inpatient			
Room & Board	100% U&C	100% U&C	$200 per day
Intensive Care	100% U&C	100% U&C	$400 per day
Hospital Miscellaneous	$1,200 per day	$900 per day	$500 per day
Surgery	80% U&C / $3,000 Maximum	80% U&C / $2,500 Maximum	80% U&C / $1,000 Maximum
Assistant Surgeon	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Registered Nurse	100% U&C	100% U&C	80% U&C
Physician Visits	$50 per day	$40 per day	$25 per day
Outpatient			
Surgery	80% U&C / $3,000 Maximum	80% U&C / $2,000 Maximum	80% U&C / $1,000 Maximum
Day Surgery Miscellaneous	$3,000 Maximum	$2,000 Maximum	$750 Maximum
Assistant Surgeon	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Outpatient Miscellaneous Benefit	$1,200 Maximum	$1,100 Maximum	$400 Maximum
Physician Visits	$50 per day	$40 per day	$25 per day
Physiotherapy	$50 per day / $800 Maximum	$40 per day / $600 Maximum	$25 per visit / 10 visit Maximum
Medical Emergency	$300 Maxiumum	$200 Maximum	$100 Maximum
X-Rays	$800 Maximum	$600 Maximum	$300 Maximum
Laboratory	$500 Maximum	$300 Maximum	$100 Maximum
Prescription Drugs	$300 Maximum	$200 Maximum	$75 Maximum
Other			
Ambulance	$1,000 Maximum	$800 Maximum	$300 Maximum
Durable Medical Equipment	$500 Maximum	$400 Maximum	$100 Maximum
Dental	$1,500 Maximum	$1,000 Maximum	$500 Maximum
AD&D	$20,000	$20,000	$10,000
Eyeglasses, Contacts, Hearing Aids	$400 Maximum	$300 Maximum	$200 Maximum

ALIVE RISK
A DIVISION OF ALL RISKS, LTD.

K-12 STUDENT ACCIDENT INSURANCE ONLINE ENROLLMENT

GREENVILLE COUNTY SCHOOLS

Contact ALIVE RISK, a division of All Risks, Ltd., for specialized insurance needs in an ever-changing market. Student accident coverage can help with copays and deductibles to those already insured. It is even more vital if your student is not insured. Protect your child with accident insurance today.

TYPES OF PLANS:

- Standard
- Economy
- Budget

COVERAGES:

- $25,000 Maximum per injury/$0 deductible
- 24-Hour Coverage (optional)
- School Time Coverage (optional)

HOW TO ENROLL:

1. Go to www.ALIVERISK.com
2. Hover over “Programs” in the top left corner of the homepage
3. Click on “K-12 Accident”
4. On the grey sidebar, click the link “Enroll today in our Voluntary Parent Purchase Coverage”
5. Find your school district and click on your child’s district name (Greenville County School District)
6. Choose the insurance program you desire and add the child’s information and Parent/Guardian information
7. Pay by credit/debit card (enter your information)
8. Click on “Submit”
9. Print out a copy of the confirmation you receive after completing the process
10. Check your email for your student’s Proof of Insurance

QUESTIONS?

CONTACT:

A-G Administrators
Luke Lyons
eMail: llyons@agadm.com
Phone: 800.634.8628
Direct: 610.933.0800
Fax: 610.933.4122

Gail Gray
McGriff Insurance Services
Student Risk Specialist
Phone: 864.672.1345
Gail.Gray@McGriff.com

McGriff
47 Airpark Ct
Greenville, SC 29607

**If you do not have access to internet and need assistance in enrolling, please contact McGriff Insurance Services at the contact info above.*

allrisks
NATIONAL SPECIALTY PROGRAMS

How to File a Claim

Do NOT expect this plan to pay 100% of the medical bills for an athletic injury. This plan pays after Primary Insurance and the benefits have internal maximum amounts that are paid out. Refer to Plan for details.

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

1. **Completed and Signed Claim Form ***SUBMIT IMMEDIATELY*****
   - Greenville County (Policy # **US1517165**)
2. **Itemized Bills**: Physician: CMS/HCFA-1500 and/or Hospital/Surgery: UB-04
3. **Explanation of Benefits (EOB's)** from your Primary Insurance Carrier

Documents should be emailed, faxed or mailed to A-G Administrators. (Policy Number: US1517165)

A-G Administrators, Inc.
Attn: Luke Lyons
P.O. Box 979
Valley Forge, PA. 19482
Email: llyons@agadm.com
Fax: (610) 933-4122
Phone: (610) 933-0800 or Toll Free: (800) 634-8628

It takes 3-5 weeks to load and process claims once all documents are received!! Contact A-G to follow up on the status if needed. For escalated issues, you may contact Gail Gray at Gail.Gray@McGriff.com.

If you have Health Insurance in addition to the Student Accident Plan:
Please make certain that the Provider knows that you have Primary and Secondary Accident Insurance. Confirm that they are willing to file all services, related to the injury, to both carriers.
**If the Provider will file to your "family/personal" insurance as Primary and then to A-G as Secondary, all you need to do is complete and submit the claim form (Refer to details below).*

If the provider will not file to both the primary and secondary insurance companies, you will need to submit copies of the following items:

1. **Claim Form**: The Claim Form enables us to open a claim for the treatment of your injury. To avoid delays in claim processing please be sure the "other insurance" portion of the claim form is completed in full. The claim form must be signed by a school official such as coach or athletic trainer.
   a. **The school is responsible for completing their portion of the claim form in the event of an injury. Once the school has done so, students/parents are responsible for completing the remainder of the form and submitting the complete claim form to A-G Administrators**.
   b. ***Submit Claim Form to Carrier within 90 Days from the date of Injury.** Do NOT wait to receive supporting documentation. Primary EOB's and CMS/HCFA-1500 Forms can be submitted as you receive them.
2. **Explanation of Benefits** (EOB's): If you have other medical insurance, all medical bills must be first submitted to that carrier for their determination of eligibility. If the charges are not paid in full by your primary medical insurance carrier A-G will need to see a copy of the "Explanation of Benefits" from that carrier prior to issuing benefits. If you have no primary medical insurance the need for an "Explanation of Benefits" will not be applicable to your claim.
3. **Itemized Bills**: Please include copies of all itemized medical bills (ie; CMS/HCFA-1500 and/or UB-O4). Account statements or "balance due" statements are helpful, but do NOT contain all the information needed to process the charges.

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

Special Risk Organization
Participant Accident Claim Form

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

Greenville County - Policy: US1517165

Special Risk Organization _____

Participant's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

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

Cell Phone _____ Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ Accident Date _____

Body Part Injured _____ Place of Accident _____

Nature of Injury — Details of What Happened _____

INSURANCE INFORMATION

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

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

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

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

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

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

_____ _____ _____
SPECIAL RISK ORGANIZATION SIGNATURE Title Date