Gallagher | STUDENT HEALTH & SPECIAL RISK

Archdiocese of Cincinnati
Student Accident Insurance Claim Form Instruction Sheet

1. **Gallagher Student Health & Special Risk/BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the school. All other sections must be completed by the parent/guardian. If your child is uninsured please indicate on the claim form that there is no primary insurance and request a copy of the "Statement of No Insurance" Form to signed and returned.

2. **Ensure you give the medical provider Gallgher Student's information for billing purposes (see below). The provider will then submit all necessary paperwork for processing claims.** If you choose to submit claims yourself, you must attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills (known as Fifteen Hundred or UB form). The itemized medical bills should show the ICD-9 and CPT codes for the services provided, as well as other necessary information for insurance processing. **Balance due statements are not itemized bills.**

3. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs.

4. Submit the completed claim form to Gallagher Student Health & Special Risk. Claims can be submitted via mail, fax, or e-mail.

Fax	Mail	Email
617-479-0860 Attn: Special Risk Dept	Gallagher Student Health & Special Risk - Special Risk Dept 500 Victory Road Quincy, MA 02171	specialrisk@gallagherstudent.com

5. You may contact Gallagher Student Health & Special Risk at 877-345-8928 to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting Gallagher Student Health & Special Risk, please have your claim form available to ensure prompt assistance.

K-12 Accident Insurance Program FAQs

Why is my child's school providing student athletic accident insurance?
Many health insurance plans have high deductibles and plan limits that leave parents with high bills resulting from an unexpected accident. This excess policy, provided by the school, protects students and families from the costs associated with school-time athletic injuries.

Who is Gallagher Student Health & Special Risk and BMI Benefits?
Gallagher Student Health & Special Risk manages the student accident insurance program for the school. You will submit all claims to Gallagher Student Health & Special Risk. Gallagher Student Health & Special Risk will make sure to that all claims are complete for submission to the claims administrator, BMI Benefits. BMI Benefits is the claims administrator which actually processes the medical claims.

Does primary insurance always have to pay first?
Yes. Medical claims must always be submitted initially to your primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

Does the accident insurance policy pay for up front out-of-pocket expenses such as co-pays and deductibles?
Yes. These charges can be submitted to the accident insurance policy to provide reimbursement for out-of-pocket expenses.

What documents are needed to process a claim?
If your student is involved in an athletic injury, the following documents are needed to properly process a claim:

- **Fully completed Insurance Accident Claim Form** – available through the school's administrative office.
- **Itemized Bill – <u>called Fifteen Hundred or UB form</u>**. This can be obtained through the provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (Fifteen Hundred or UB form) contains the following information:
    - Provider's Name, Provider's Address, Tax ID Number
    - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
    - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** – you should receive a copy of this from your primary insurance carrier.

Where do I send all of these documents?
Please send all claim forms and other correspondence to Gallagher Student Health & Special Risk.

What insurance information do I have to give a provider?
When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your schools student accident medical insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the itemized bill to Gallagher Student Health & Special Risk. If you did not submit the secondary insurance information upon your first visit, please call the provider and tell submit the secondary insurance information to them. If the provider bills the school's student accident insurance policy directly, this will prevent a balance due statement from being sent to the student/parent.

What can cause a delay in processing and paying a claim?
The claims administrator cannot process a claim that is missing one or more of the following documents: the accident/injury claim form, the Itemized Bill or the Primary EOB / denial. We cannot accept balance due, balance forward, or past due statements for claims processing.

Who can I contact if I have any questions?
If you have questions after you submit your claims to Gallagher Student Health & Special Risk, please contact them at 877-345-8928.

Gallagher | STUDENT HEALTH & SPECIAL RISK

Gallagher Student Health & Special Risk
Student Accident Insurance Team Contact Sheet

Archdiocese of Cincinnati

Resource	Responsibilities	Contact Information
Dan Helbach Account Executive Gallagher Student Health & Special Risk	• Global account management issues • Renewal Planning • Plan Implementation • Escalated requests or problem resolutions • Focus on sports and special risk insurance needs for colleges & universities, K-12 public and private institutions	dan_helbach@ajg.com 800-457-5599, x6471
Kelly Ethier Client Service Representative Gallagher Student Health & Special Risk	• Marketing Materials • Day to day account management • Benefit Questions • Claims Assistance	Kelly_ethier@ajg.com 800-457-5599, x6471
Claims Company	• Claims processing • Online claims status • Benefit Questions • Claims Assistance	**BMI Benefits, LLC. Matawan, NJ 07747 Ph: 1-800-445-3126 Fax: 732-583-9610**

Important Note: All claims forms, itemized bills and primary insurance EOBs should be submitted directly to BMI Benefits. If you have claim questions, you should contact BMI Benefits directly. If you have any issues or concerns, feel free to contact Gallagher Student Health & Special Risk directly at the contact information above.

HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC, P O Box 511, Matawan, NJ 07747/1-800-445-3126 -- Fax: 732-583-9610

ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

Got You Covered

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization: Archdiocese of Cincinnati | Policy#: 11KTT8190903

School Mailing Address | City, State, Zip

Injured Person's Name | Birth date | Male ☐ Female ☐

Date of Injury | Time | Type of Sport | Part of body injured

How did Injury occur?

Sport Designation: Intercollegiate ☐ Intramurals☐ Practice ☐ Game ☐ Other ☐

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ☐ NO ☐

Name of Supervisor | Was he/she a witness to the accident? YES ☐ NO ☐

Signature of Supervisor/Official | Title | Date

PART 1 B: INJURED PERSON'S INFORMATION
THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number

Injured Person's Home Address (Street, City, State, Zip)

Is the injured Person Employed? YES ☐ NO ☐ If yes, please fill out Section A below.

Is the injured Person Married? YES ☐ NO ☐ Spouse's Name

Is the Spouse Employed? YES ☐ NO ☐ If yes, please fill out Section B below.

Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ☐ NO ☐
If Yes: Name of Insurance Carrier _____ Policy #: _____

PARENT/GUARDIAN INFORMATION

Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES ☐ NO ☐	Is the Mother Employed? YES ☐ NO ☐

SECTION A (INSURED/FATHER)	SECTION B (SPOUSE/MOTHER)
Employer	Employer
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Business Phone	Business Phone
Insurance Company Policy#	Insurance Company Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant or Authorized Person's Signature | Date

ELIGIBILITY
Any enrolled student who attends Archdiocesan pre-kindergarten, kindergarten, elementary or secondary school is eligible. Any student while participating in CYO activities is also eligible.

COVERAGE
COMPULSORY SCHOOL TIME ACCIDENT COVERAGE FOR ALL STUDENTS – Insurance coverage for covered Injuries during the hours and days when school is in session and while: (a) participating in school sponsored and supervised activities occurring on or off school premises, including participation in CYO activities; or (b) traveling to and from such activities in transportation furnished or arranged by the school. Includes participation in Summer Activities and travel to and from school and excludes participation in High School Interscholastic Sports and Football.

PRIMARY
Benefits are payable up to the policy maximum for Covered Accident Medical Service(s) expenses.

$25,000 STUDENT ACCIDENT MEDICAL EXPENSE BENEFITS
When a covered Injury to an insured results in treatment by a physician beginning within 90 days after the date of the accident, the Company will pay Usual and Customary Charges up to $25,000 per Injury. Only covered accident medical service expense(s) incurred by the insured within 730 days from the date of the accident are payable.

INPATIENT HOSPITAL SERVICES – Daily Room and Board, Intensive Care Room and Board, Miscellaneous Services during hospital confinement, including all services billed by the facility
OUTPATIENT HOSPITAL SERVICES – Emergency Room when hospital confinement is not required, including all services billed by the facility, and Ambulatory Medical Centers and outpatient operating room
PHYSICIAN'S SERVICES – Surgery including pre- and post-operative care, Anesthesia (including administration) and Assistant Surgeons when medically necessary, Physician's visits other than for Physiotherapy or similar treatment when no surgery benefit is paid beginning on the first day treatment is rendered, and Consultants and second opinions when required by attending Physician for confirming or determining a diagnosis, but not for treatment
X-RAY, MRI AND LABORATORY SERVICES – X-rays including fee for interpretation and/or reading of x-rays (Dental x-rays are payable under dental services benefits shown below.), Laboratory Services and MRI/CatScan
ADDITIONAL SERVICES – Physiotherapy or similar treatment including Diathermy, Ultrasound, Microtherm, Manipulation, Massage and Heat, Registered or licensed nurse in or out of Hospital when medically necessary and prescribed by a Physician, Ambulance to initial treatment facility, Durable Medical Equipment when prescribed by a Physician including rental of crutches or a wheelchair, Drugs and Medications, when prescribed by a Physician, Eye glasses, Contact Lenses and Hearing Aids: Replacement of broken glasses and/or frames, contact lenses and hearing aids resulting from a covered injury requiring medical or surgical treatment
DENTAL SERVICES – Treatment, repair or replacement of each injured natural tooth. This will include Expenses incurred for initial braces when required for treatment of a Covered Injury, examination, diagnosis, x-rays, restorative treatment, endodontics, oral surgery and treatment for gingivitis resulting from trauma.
EXTENDED DENTAL SERVICES – Replacement of caps, crowns, dentures or orthodontic appliances (including braces) when damaged in a covered accident. When a dentist certifies within the benefit period that treatment will continue beyond the expense incurral period, deferred benefits will be paid to a maximum of $1,000.00 per accident. If there is more than one way to treat a particular dental problem, benefits will be paid for the least expensive procedure if it meets accepted dental standards.

ACCIDENT MEDICAL PLANS INCLUDE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
If Injury to the Insured results within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the Maximum Amount shown below for that Loss. For Loss of:

• Life	$15,000
• Both Hands or Both Feet or Sight of Both Eyes	$30,000
• One Hand and One Foot	$30,000
• One Hand and the Sight of One Eye	$30,000
• One Foot and the Sight of One Eye	$30,000
• Speech and Hearing in Both Ears	$30,000
• One Hand or One Foot or Sight of One Eye	$15,000
• Speech or Hearing in Both Ears	$15,000
• Hearing in One Ear	$7,500
• Thumb and Index Finger of the Same Hand	$7,500

"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 hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and 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.

DEFINITIONS
Ambulatory Medical Center - means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician's office.

Hospital - as used in this Rider, means a facility that: (1) is operated according to law for the care and treatment of injured and sick people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Injury - means bodily injury caused by an accident that: (1) occurs while the Policy is in force as to the person whose injury is the basis of claim; (2) occurs while such person is participating in a Covered Activity; and (3) results directly and independently of all other causes in a covered loss.

Insured - means a person: (1) who is a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; (2) for whom premium has been paid; and (3) while covered under the Policy.

Medically Necessary - means a Covered Accident Medical Service that: (1) is essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

Physician - means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Usual and Customary Charge(s) - means a charge that: (1) is made for a Covered Accident Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred; (3) does not include charges that would not have been made if no insurance existed.

EXCLUSIONS AND LIMITATIONS

This Policy does not cover any loss or Injury resulting or caused, in whole or part, from: 1) Suicide or attempted suicide; self-destruction or attempted self-destruction; while sane or insane 2) Intentionally self-inflicted injury 3) War or any act of war or invasion; declared or undeclared. 4) Sickness; disease; bodily or mental infirmity; or any bacterial or viral infection; or medical or surgical treatment thereof, except for any bacterial infection that results from: accidental ingestion of contaminated food substances; or pyogenic infections that result from an accidental external cut or wound. 5) Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline. 6) Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician. 7) Intoxication or being under the influence of any drug or narcotic. Intoxication is defined by the laws of the jurisdiction where such Accident occurs. Violation of or attempt to violate any duly-enacted law or regulation; or commission or attempt to commit an assault; felony; or other illegal activity. 8) Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy. 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. 9) Travel or activity outside the United States. 10) Travel in or on any off road and on road motorized vehicle not requiring licensing as a motor vehicle. -- In addition to the exclusions above, We will not pay Accident Medical Expense or Additional Accident Benefits for any loss, treatment or services resulting from or contributed to by: 1) Treatment by persons employed or retained by a Policyholder; or by any Immediate Family; or member of the Covered Person's household. 2) Treatment of sickness; disease; or infections except pyogenic infections or viral or bacterial infections that result from the accidental ingestion of contaminated food substances. 3) Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy). 4) Expense incurred for treatment of temporomandibular; or craniomandibular joint dysfunction; and associated myofacial pain (except as provided by the Policy). 5) Injury paid by Workers' Compensation; Employer's Liability Laws; or similar occupational benefits; or while engaging in activity for monetary gain from sources other than the Policyholder. 6) Injury or loss contributed to by the use of drugs unless administered by a Doctor. 7) Injury or death to which a contributing cause is the Covered Person's violation or attempt to violate any duly-enacted law; or the commission or attempt to commit an assault or a felony; or that occurs while the Covered Person is engaged in an illegal occupation. 8) Covered medical expenses for which the Covered Person would not be responsible for in the absence of this Policy. 9) Any elective treatment; surgery; health treatment; or examination; including any service; treatment; or supplies that: (a) are deemed by Us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States. 10) Blood, blood plasma; or blood storage; except expenses by a Hospital for processing or administration of blood. 11) Cosmetic surgery; except for reconstructive surgery needed as the result of an Injury.

CLAIMS PROCEDURES – In case of accident, notify school immediately. Secure claim form from school, attach itemized bill(s) to completed claim form and mail to address indicated on claim form. CLAIMS FOR BENEFITS MUST BE FILED WITHIN 90 DAYS FROM DATE OF LOSS. The Company must be notified of a loss within 30 days of such loss.

This is only a brief description of the coverage available under the Master Policy. The Policy may contain reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the Master Policy. If there is any conflict between the contents of this document and the Master Policy, the Master Policy shall govern. Individual policies will not be issued or sent to you. A master Policy will be issued to the Finance Office of the Archdiocese of Cincinnati and is on file for your review.

STUDENT/ATHLETIC ACCIDENT PROGRAM 2014-2015

Most Reverend Dennis M. Schnurr and Successors, Roman Catholic Archbishop of the Archdiocese of Cincinnati as Trustee of the Properties Under his Jurisdiction

Program Manager:
Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
Ph: 877-345-8928

Claims Administrator
BMI Benefits, LLC.
P O Box 511
Matawan, NJ 07747
Ph: 1-800-445-3126
Fax 732-583-9610

IMPORTANT NOTICE:
The Plan provides **ACCIDENT** insurance only. It does **NOT** provide basic hospital, basic medical or major medical for sickness coverage.

This plan is underwritten by Arch Insurance Company, a Missouri Corporation (NAIC # 11150). Executive offices are located at One Liberty Plaza, New York, NY 10006