Alaska Public Risk Alliance

September 2025

Dear Parent or Guardian:

Your child's school district has obtained ***Student Accident Coverage*** through the Alaska Public Risk Alliance (APRA) to help with the cost of medical care that may be required if your student is injured at school or during a school-related activity. This coverage is provided at no cost to you.

This coverage provides benefits on an excess basis to your child's underlying health insurance coverage (including coverage through the Indian Health Service or Denali Kid Care) and will reimburse you for all or some of the out-of-pocket costs you would otherwise be responsible for. If your child is not covered by any health insurance, this coverage will cover eligible medical costs related to their injury. A Summary Description of Benefits is enclosed for your reference.

This Student Accident coverage includes a basic layer of coverage funded by APRA, and higher limits coverage for serious accidents that is provided through a policy purchased from ACE American Insurance Company. Claims are processed by Myers-Stevens and Toohey, Inc. (MST), which has been engaged by APRA to assist with this coverage. To file a claim under this student accident coverage, please complete the attached claim form and send it to claims@myers-stevens.com, and a representative from MST will contact you with any follow-up questions .

If your child requires medical care for their injury, bills for that care should first be submitted to the child's regular health insurance carrier. After the health insurance carrier has paid their share of the bill, they will send you an "Explanation of Benefits" (EOB) documenting what portion of the expenses have been paid and their reasoning why other portions have not been paid. You then need to submit the EOB and the itemized bills from the provider as described on the attached claim form.

It is not necessary to wait until you have received an EOB before filing a claim under this coverage, and we encourage you to do so as soon as possible after the student's injury.

If you have any questions about this coverage, or when or how to file a claim, please contact Jane Starr at MST at jstarr@myers-stevens.com or at (800) 827-4695 x607.

Student Accident Coverage
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)

Coverage terms and conditions

If your child is injured, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. Coverage summaries may be obtained from your school or school district or by contacting Myers-Stevens & Toohey at (800) 827-4695.

Claim form and reporting

Report school-related injuries immediately to school officials, providing as much detail as possible.

Request a claim form from the school and ask an authorized school official to ***completely and clearly*** fill out Part A of the form. Only one claim form is required per injury or condition.

Completely and clearly fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to Myers-Stevens & Toohey along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

When treatment is sought

- Give the provider's billing/admissions department your primary insurance/health plan information (if applicable).
- Let the provider know that your child has student accident coveragethrough his/her school and that medical expense benefits are provided on an excess or secondary basis.
- Request the billing department to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If your child has other insurance or health coverage

File a claim with that primary plan and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what your child is being treated for
- Procedural or Revenue Codes - these tell us what was done to evaluate/ treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

MYERS-STEVENS & TOOHEY
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

OR **Fax: (949) 348-9350** *OR* **Email: claims@myers-stevens.com**

Need more help? Call us at (800) 827-4695

STUDENT ACCIDENT COVERAGE CLAIM FORM

"School-Time" plan ($25,000 maximum benefits per injury) is fully self-funded by APRA and the catastrophic injury and other insured coverages are underwritten by ACE American Insurance Company (a CHUBB member company)

Alaska Public Risk Alliance

myers | stevens | toohey

PART A SCHOOL STATEMENT

NAME OF CLAIMANT FIRST	MI	LAST	AGE	GRADE	☐ FEMALE ☐ MALE	DATE OF BIRTH MO DAY YR

ADDRESS OF CLAIMANT | CITY | STATE | ZIP CODE

IS THE CLAIMANT A:
☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____

NAME OF SCHOOL | NAME OF DISTRICT

SCHOOL MAILING ADDRESS | CITY | STATE | ZIP CODE | SCHOOL TELEPHONE NUMBER

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP
OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION:

TYPE OF SPORT:

DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO
If YES, name of plan:

DATE OF INJURY/SICKNESS | TIME OF INJURY : A.M. / P.M. (Circle One) | WHAT **PART** AND/OR **AREA** OF THE BODY WAS INJURED? (Additional details may be provided below) ☐ RIGHT _____ ☐ LEFT _____ | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL WAS NOTIFIED

NAME AND TITLE OF OFFICIAL COMPLETING FORM | EMAIL | SIGNATURE X | DATE SIGNED

PART B STUDENT INFORMATION - TO BE COMPLETED BY PARENT OR GUARDIAN

NAME OF CLAIMANT'S (STUDENT'S) PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT, UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
YES, NAME OF PLAN(S) | POLICY NUMBER(S) | **IS THE CLAIMANT A MEDICARE BENEFICIARY?** ☐ **YES** ☐ **NO**

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER

NAME OF FATHER OR LEGAL GUARDIAN | EMAIL | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF MOTHER OR LEGAL GUARDIAN | EMAIL | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or APRA when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School activity, I authorize MST to share information concerning this claim as necessary with representatives of the School/School District. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law. I have read and acknowledge the General Fraud Warning above.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

STUDENT/VOLUNTEER ACCIDENT MEDICAL EXPENSE COVERAGE SUMMARY

DESCRIPTION OF BENEFITS - 2025-2026 SCHOOL YEAR

We will pay Usual, Customary and Reasonable (UCR) medical and dental charges for necessary supplies and services, as defined by the policy, subject to exclusions, requirements, and limitations as follows.

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Services 1. Daily Room & Board - Semi-Private 2. Intensive Care Room & Board 3. Miscellaneous Services - when hospital confined or when surgery is performed. 4. Emergency Room (outpatient)	100% of UCR
Physician Services 1. Surgery, including pre-and postoperative care 2. Anesthetic (including administration and Assistant Surgeon 3. Physician Visits 4. Consultants and Second Opinions.	100% of UCR
Laboratory & X-Rays 1. Includes reading and interpretation 2. Diagnostic Imaging/MRI/Cat Scan 3. Dental x Rays	100% of UCR
Additional Services 1. Physiotherapy or similar treatment; 2. Registered or Licensed Nurse 3. Ambulance to initial treatment facility including Air Transport 4. Orthopedic Appliances (includes rental of crutches or wheelchair) 5. Prescribed Drugs or Medicines 6. Eyeglasses, when damaged in conjunction with a covered injury.	100% of UCR
Dental Services Treatment, repair or replacement of injured natural teeth. Includes initial braces when required for treatment of a Covered Accident, as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma.	100% of UCR

PLAN LIMITS AND DEDUCTIBLE

Plan Limits 1. Base Plan 2. Catastrophic Benefits 3. Extended benefits for the most seriously injured students 4. Accidental Death 5. Paralysis and dismemberment	 1. $25,000 per injury 2. $1,000,000 3. Up to $500,000 4. $25,000 5. Up to $50,000
Deductible	$0 per injury

DESCRIPTION OF COVERED PERILS

Coverage is provided for injuries occurring to the covered person:

1. While traveling directly without interruption between home and school to attend classes and/or participate in school sponsored and supervised activities.
2. While on campus for up to one hour before instruction begins and for up to one hour after instruction ends.
3. At school during the school day while continuously on school premises (including academic summer classroom sessions) and
4. While attending or participating in activities sponsored and under the direct and immediate supervision of the school
5. While traveling in school provided and operated vehicles.
6. While traveling directly and without interruption between school and the site of an activity sponsored and under the direct and immediate supervision of the school, provided that such travel has been arranged by and is at the discretion of the school.
7. While attending school sponsored and supervised field trips or excursions within the United States or Canada of up to seven consecutive days duration.

DESCRIPTION OF EXCLUDED PERILS (including but not limited to)

Coverage is excluded for the following situations and injuries:

1. Treatment by employees of the Member if such treatment was provided within the course and scope of the person's employment, and the Medical Cost was not billed to or on behalf of the Covered Party as medical services.
2. Treatment of Osgood-Schlatter's Disease, appendicitis, osteomyelitis, osteochondritis, temporomandibular joint dysfunction and associated myofascial pain, cardiac disease or conditions, pathological fractures, congenital weakness, hernia, detached retina (unless directly caused by an injury), mental disorder, or psychological or psychiatric care or treatment.
3. Bodily Injury to any person while acting or performing any duties within the course and scope of his or her employment by the Member or any other person or entity, or while receiving compensation of any type from the Member or any other person or entity, or that is covered by any workers' compensation or employer's liability law.
4. Bodily Injury caused by or contributed to by the use of alcohol or drugs, unless administered by or on the advice of a licensed medical provider.
5. Bodily Injury to which a contributing cause is the Covered Party's commission or attempt to commit an assault or felony, or that occurs while the Covered Party is engaged in an illegal activity, pursuit, or occupation.
6. Medical Costs for which a Covered Party would not be responsible in the absence of Agreement E.
7. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment.
8. Treatment by any relative or family member of the Covered Party, unless the Medical Cost for the treatment was billed to or on behalf of the Covered Party as medical services by or through an appropriately licensed and accredited medical practice or facility.

CLAIM ELIGIBILITY

School-related injuries should be reported to school officials with 10 days; initial evaluation by a physician, nurse practitioner, or physician's assistant must be obtained within 120 days of the date of injury.

This document is not meant to expand or amend the APRA or ACE American Insurance Company coverage documents, nor should it be used in the determination of liability for any particular claim. For specific details, please refer to the coverage documents and other official coverage forms. All matters of interpretation are to be construed in favor of these documents.