



# BOYERTOWN AREA SCHOOL DISTRICT

EDUCATION CENTER

**Safety & Well-Being Acceptance & Respect Communication & Collaboration Learning & Growth**  
*To cultivate an exceptional, innovative learning community that enables all students to succeed in a changing world.*

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August 2023

Dear Parent/Guardian:

Each year, the Board of School Directors offers voluntary student accident insurance coverage to all the students. The following is a short summary of this Primary Excess policy.

The school district does not carry medical insurance on students, but offers a Primary Excess Group Insurance Plan that:

- Provides broad student accident coverage: most school sponsored and supervised activities including regular school session, summer school, direct travel to and from regular school sessions, direct and uninterrupted travel to and from school activities as well as participation in school activities (except injuries sustained as a result of practice or participating in any form of school sponsored tackle football).
- The 24-HOUR ROUND THE CLOCK PLAN provides coverage on a 24-hour per day basis – during school hours, after school, evenings, weekends, holidays, and summer vacations.
- Optional coverage includes Voluntary Student Accident Insurance.
- Pays benefits directly to you, or the doctor, or the hospital.
- **Please see the following brochure for specific coverage information.**
- **Contact A-G Administrators – [agadministrators.com](http://agadministrators.com), 610.933.0800 if any questions.**

If you are interested in purchasing Voluntary Student Accident Insurance, please complete the **enrollment form** in the following brochure. The enrollment form, along with your check or money order, should be mailed directly to **A-G Administrators at PO Box 824936, Lock Box # 824936, Philadelphia, PA 19182-4936**. Make Checks Payable to UNITED STATES FIRE INSURANCE COMPANY c/o A-G Administrators LLC.

Parents/Guardians have the option to select the appropriate coverage:

Voluntary Student Accident Insurance	School Time Coverage	\$ 22.50 per student, per year
	24-Hour Coverage	\$ 90.00 per student, per year

The parents/guardians must file a claim with both his/her own insurance company and the school district's voluntary student accident insurance company within 90 days of the date of injury.

Sincerely,

Patricia J. Denicola  
Chief Financial Officer

# K-12 Voluntary Student Accident Insurance up to \$250,000

## 2023-2024



Administrative Office  
A-G Administrators LLC  
Berwyn, PA USA  
Phone (610)933-0800  
[www.agadministrators.com](http://www.agadministrators.com)

Plans are Underwritten by  
United States Fire Insurance Company



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## ***K-12 Accident Insurance***

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### **Unexpected Accidents Can Happen**

This brochure explains how you can help guard against certain unexpected events. Our plans are designed to help supplement any insurance you have by satisfying deductibles or co-insurance requirements, or limiting the possible financial impacts of an injury if you have no other insurance. Remember that the more active your child is, the more valuable this coverage can be.

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### ***Choose Your Coverage Plan***

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**24-Hour Coverage (Accident Only)** – This plan provides around the clock coverage to your child 24-hours a day, while he or she is in school, at home or away. Coverage is provided from the effective date of the insured student’s coverage for which premium has been received by A-G to the opening of the next school term. **Excludes all interscholastic sports.** (\$90.00)

**School Time Coverage (Accident Only)** – This plan provides coverage to your child while he or she is on school premises, during school hours/days, attending school sponsored and supervised activities including travel directly without interruption between the student’s residence and school/activity with transportation furnished by the school. Coverage is provided from the effective date of the insured student’s coverage for which premium has been received by A-G to the end of the regular school term. **Excludes all interscholastic sports.** (\$22.50)

## Description of Benefits

Benefit	24 Hour Coverage/School Time Coverage
<b>Benefits provided for all enrolled students of the Policyholder excluding interscholastic sports for whom premium is paid.</b>	
<b>Maximum Benefit:</b>	\$250,000; \$15,000 payable as shown below, excess of \$15,000 payable at 100% Usual, Reasonable and Customary Charges
<b>Deductible:</b>	\$0
<b>Benefit Period:</b>	52 Weeks
<b>Hospital Services</b>	
<b>Daily Room &amp; Board:</b> Semi Private Room	\$300 per day
<b>Miscellaneous Hospital Services:</b> During hospital confinement	\$3,000
<b>Intensive Care:</b> When confined to a Hospital Intensive Care Unit	\$700 per day, not to exceed 10 days
<b>Emergency Room Charges:</b> When hospital confinement is not required	\$400 Maximum
<b>Emergency Room Charges:</b> If out-patient surgery is required, the maximum is increased to (The benefits are payable in addition to the X-rays and surgeon's services shown below.)	\$1,500 Maximum
<b>Physician Services</b>	
<b>Surgery:</b> including pre- and post-operative care*	\$170 Unit Value
<b>Anesthesia:</b>	40% of the Surgery Benefit Paid
<b>Assistant Surgeon:</b>	40% of the Surgery Benefit Paid
<b>Doctor's Visit:</b> other than for Physiotherapy or similar treatment not payable in addition to Surgery Benefit	100% UCR
<b>Non-Surgical doctor's charges in the emergency room</b>	\$70 per visit
<b>Second Surgical Opinion, Consultation and Specialists</b>	\$150 aggregate benefit
<b>Laboratory and X-Ray Services</b>	
(Other than Dental and including fee for interpretation and/or reading of X-rays.)*	\$20 Unit Value
<b>Lab and X-Ray:</b> (when no fracture is demonstrated)	\$400 Maximum
<b>Additional Services</b>	
<b>Physiotherapy or similar treatment:</b> including Diatherm, Ultrasonic, Microtherm, Manipulation, Massage and Heat	\$50/Treatment Maximum of \$500
<b>Registered Nurse:</b>	100% UCR
<b>Ambulance Transportation:</b> (Ground Only)	\$300 Maximum
<b>Orthopedic Appliances:</b> When ordered by attending physician	\$500 Maximum
<b>Out-Patient Drugs and Medication:</b> Administered in Doctor's office or by prescription	100% UCR
<b>Dental (including X-rays):</b> For treatment, repair or replacement of each injured tooth which was sound and natural at the time of injury	\$200 per tooth
<b>Eyeglasses, Contact Lenses:</b> Replacement of broken glasses and/or frames, contact lenses, resulting from a covered injury	\$100 maximum
<b>Accidental Death Benefit</b>	\$2,500
<b>Accidental Dismemberment, Loss of Sight</b>	\$20,000
* In accordance with the 1974 Revised California Relative Values Studies, 5 <sup>th</sup> Addition, using a conversion factor.	

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## ***Policy Exclusions***

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### **Benefits will not be paid for a Covered Person's loss which:**

- (1) Is caused by or results from the Covered Person's own:
  - (a) Intentionally self-inflicted Injury, suicide or any attempt thereat. (In Missouri this applies only while sane.);
  - (b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);
  - (c) Commission or attempt to commit a felony;
  - (d) Participation in a riot or insurrection;
  - (e) Driving under the influence of a controlled substance unless administered on the advice of a doctor; or
  - (f) Driving while Intoxicated. "Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs;
- (2) Is caused by or results from:
  - (a) Declared or undeclared war or act of war;
  - (b) An Accident which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.);
  - (c) Aviation, except as specifically provided in this Certificate;
  - (d) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.
  - (e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
    - (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
    - (ii) The Covered Person was within a 25-mile radius of the site of the release either:
      - 1) At the time of the release; or
      - 1) Within 24 hours of the start of the release.

### **Benefits will not be paid for:**

1. Normal health check ups
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
  - a. Employed or retained by the Certificateholder; or
  - b. Who is the Covered Person or a member of his immediate family;
4. Charges which:
  - a. The Covered Person would not have to pay if he did not have insurance; or
  - b. Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
  - a. An aircraft, except as a fare-paying passenger;
  - b. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
  - c. An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
  - a. A snowmobile;
  - b. Any two or three wheeled motor vehicle;
  - c. Any off-road motorized vehicle not requiring licensing as a motor vehicle;

7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. That part of medical expense payable by any automobile insurance policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
  - a. The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
  - a. Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food;
11. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;
12. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Certificate;
13. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
14. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
15. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
16. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
17. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
18. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
19. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
20. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
21. Any loss which is covered by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
22. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
23. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
24. Services and supplies furnished by a Student Infirmary, its employees, or doctors who work for the School;
25. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits; or
26. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound.
27. Rest cures or custodial care;
28. Prescription medicines unless specifically provided for under the Certificate;
29. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;

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## **How to Enroll**

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1. Determine which plan of coverage you would like to enroll your child in - 24 Hour Coverage or School Time Coverage
2. Fill out the Enrollment Form below, enclose a check or money order in an envelope payable to the Company for the correct amount and mail to A-G Administrators LLC PO Box 824936 Lock Box # 824936 Philadelphia, PA 19182-4936
3. Make Checks Payable to UNITED STATES FIRE INSURANCE COMPANY c/o A-G Administrators LLC
4. Return by mail to A-G Administrators LLC. Your cancelled check or money order stub will be your receipt and confirmation of payment. Please write student's name and school name on your check).

**INDIVIDUAL VOLUNTARY STUDENT ENROLLMENT FORM  
UNITED STATES FIRE INSURANCE COMPANY  
STUDENT ACCIDENT COVERAGE**

STUDENT'S LAST NAME (one letter per box)

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STUDENTS FIRST NAME

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Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of School \_\_\_\_\_

School District \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian (Required)

**Individual Voluntary  
Student Accident Plans**

**24-HOUR COVERAGE**

\$90.00 per student per year

**SCHOOL TIME COVERAGE**

\$22.50 per student

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## **Period of Coverage**

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Persons applying for coverage shall be covered as of the date premium receipt, but in no event prior to the opening of school activities. Coverage ends at the close of the regular school term, except under 24-Hour Coverage, which continues until school reopens for the fall term. You may enroll at any time, but premiums will not be prorated.

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## ***Questions and Answers***

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Q. Is this Policy primary or secondary coverage?

A. This policy is Primary – meaning A-G will pay valid medical expenses payable without regard to any other valid and collectible insurance plan.

Q. May we purchase the policy at any time during the year?

A. Yes, coverage may be purchased at any point in time during the school year for your child. However, there is no pro-rating of premium for enrollment that occurs after the policy effective date. The earlier you enroll the more your child will maximize their coverage.

Q. Will this policy pay if our other insurance has a deductible?

A. Yes, benefits are paid without regard to other insurance.

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## ***How to File a Claim***

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1. Obtain an accident claim form through A-G Administrators LLC at [customerservice@agadm.com](mailto:customerservice@agadm.com). Please answer all questions and provide all necessary signatures.
2. Attach all itemized bill(s) and any explanation of benefits to the claim form and mail or fax to the Administrator's Address indicated on the claim form.
3. Claims for benefits must be filed within 90 days from the date of accident. Only one claim form is needed per accident.

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## ***Important Note***

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This brochure is a summary of the insurance plan as specified in the policy form (BA-50000P-USF) on file with the School. This brochure is subject to the terms and conditions of the Policy, which contains all benefits, limitations and exclusions as underwritten by United States Fire Insurance Company. This coverage may not be available in all states and Policy terms and conditions may vary by state. In the event of a discrepancy, the Policy with prevail.





# K-12 STUDENT

## ACCIDENT CLAIM FORM

Please complete and submit to A-G Administrators with itemized medical bills **AND primary insurance explanation of benefits.**

Send all claim forms and documents using our secure upload portal: [upload.agadministrators.com](https://upload.agadministrators.com)  
Alternatively, submit documents to [claims@agadm.com](mailto:claims@agadm.com).

For **questions**, however, please contact A-G Administrators: [customerservice@agadm.com](mailto:customerservice@agadm.com).

### YOUR INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ School/Organization Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### POLICYHOLDER INFORMATION

Policyholder (School): \_\_\_\_\_

School Address: \_\_\_\_\_  
STREET CITY STATE, ZIP

### STUDENT INFORMATION

Student's Name: \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth: \_\_\_\_\_ Sex:  M  F Social Security #: \_\_\_\_\_

Student's Phone Number (or Parent's if minor): \_\_\_\_\_

Student's EMAIL (or Parent's if minor): \_\_\_\_\_

Student's Home Address: \_\_\_\_\_  
STREET CITY STATE, ZIP

### ACCIDENT INFORMATION

Circumstance:  Game  Practice  Conditioning  Other (Please explain in Nature of Injury section.)

Type of Activity:  Club Sport  Intramural  Interscholastic  Non-Athletic

Activity/Sport (if athletic related): \_\_\_\_\_ 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 documents if necessary.)

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
STREET CITY STATE, ZIP

Policy Number: \_\_\_\_\_ ID#: \_\_\_\_\_

Is the student eligible for Medicaid or TriCare Benefits? \_\_\_ YES \_\_\_ NO

If yes, please file for benefits under the Student Accident Plan before submitting expenses to Medicaid or TriCare.

## 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.

**WARNING:** New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

SCHOOL OFFICIAL SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

**FRAUD WARNING:** Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Alaska:** 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.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties

**Arkansas and Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, 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.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** 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.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Idaho and Indiana:** Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony. Idaho and Indiana: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

**Kentucky:** 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.

**Louisiana and West Virginia:** 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.

**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person, who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison