

RUTHERFORD COUNTY SCHOOLS
Group Athletic Accident Insurance
Eagleville School

2015-16

TO: Parent/Guardian:

Following is information outlining the benefits, limitations, and exclusions of the accident insurance program. Please note that the insurance is "secondary" to any other insurance coverage the family may have and will pay only on medical expenses not payable by other sources of coverage.

BENEFITS
If accidental bodily injury occurs while practicing for or competing in athletics and requires treatment within 30 days from the original date of injury by a licensed physician or treatment in a legally constituted hospital, the insurance company will pay the reasonable and customary expenses (see **LIMITATIONS** below) for necessary medical, dental or hospital care provided within one year from the date of the injury up to the policy maximum amount for any one injury, **which are not paid by other collectible insurance plans. You will have free choice of a physician and/or hospital for treatment. However, if your child is insured by any insurance plan and that plan requires treatment by a particular network of physicians and/or hospitals and if you choose not to use your assigned network, the school plan will pay benefits as if your other plan's network guidelines had been followed.**

CLAIM PROCEDURE

- 1) Present a claim to your own insurance company **FIRST**. After a settlement has been made with your insurance company, make certain all questions on the claim form are completed.
- 2) a. A school official must complete Part A on the claim form. b. The parent or guardian must complete Part B.
- 3) Attach all medical bills (doctors, hospitals, etc.) to the claim form.
- 4) **Attach either proof of benefits paid by your insurance company or their letter of denial.**
- 5) Mail completed claim form to: SCHOLASTIC INSURORS, INC., P.O. BOX 3194, JOHNSON CITY, TN 37602.

TREATMENT MUST COMMENCE WITHIN 30 DAYS.
**** NOTE ** SUBMIT A CLAIM TO COMPANY WITHIN 90 DAYS FROM THE DATE OF ACCIDENT. **NOTE****
BENEFITS AVAILABLE FOR ONE YEAR FROM DATE OF INJURY.

BENEFIT LIMITATIONS

- Hospital Inpatient (\$250/day of hospital confinement)
- Outpatient hospital charges - Surgical (\$200 maximum)
- Physician's surgery/fracture care fees (60% of U & C \$1,000 maximum)
- Dental (\$100 per tooth)
- Motor Vehicle (\$500 per injury)
- Diagnostic x-rays, MRI's, CAT Scans (\$200 per injury)
- Physical Therapy (\$15/visit - \$75 maximum)
- Outpatient hospital charges - Non-surgical (\$50 maximum)
- Physician's non-surgical visits or consultations (\$15/visit)
- Ground Ambulance (\$25 maximum per injury)
- Orthopedic Appliance (\$25 maximum)

EXCLUSIONS...THE POLICY DOES NOT COVER

1. Contact lenses or hearing aids; damage to other than whole, sound, natural teeth or to existing dental bridge, crowns, restorations, or braces; orthodontic procedures and services; drugs, injections, miscellaneous supplies and medications except while hospital confined.
2. Boils, athlete's foot, impetigo or similar skin infections, rashes, poisonous vegetation reactions, warts, blisters, calluses, cramps, muscle spasms, allergies or allergic reactions, ingrown nails, appendicitis, hernia of any kind, however caused; infections occurring other than as a result of such injury; detached retina; or psychiatric care.
3. Any form of illness, sickness or disease including but not limited to the following: Perthes Disease, Osgood-Schlatter's Disease, Osteomyelitis, Oseteochondritis, Osteogenesis Imperfecta, Slipped Capital Femoral Epiphysis, Thrombophlebitis, Hysterical Reactions, or similar conditions.
4. Any form of criminal or felonious assault or the insured's being engaged in an illegal occupation.
5. Services or treatment rendered as a part of the school service by a hospital, physician, or person employed or retained by the Sponsor, or by a person related to the Covered Person by blood or marriage.
6. Riding in or on, being struck by, being towed by, boarding or alighting from, or operating any motorized or engine driven vehicle; provided, however, that eligible medical expenses not collected from other valid coverage will be payable up to \$500.00 in the aggregate.
7. Intentionally self-inflicted injury. War or act of war.
8. Injuries sustained by a Covered Person hereunder for which benefits are payable under any Workmen's Compensation or Employer Liability Laws, or while engaging in activity for monetary gain from sources other than the school.
9. Aviation in any form except while the Covered Person is riding as a passenger in a licensed airplane provided by an incorporated passenger carrier on a regularly scheduled passenger flight and route.
10. Riding in or on, being struck by, being towed by, boarding or alighting from, or operating any snowmobile or two or three wheeled motor vehicle.
11. The use of or while under the influence of drugs or intoxicants unless administered as prescribed by a physician.
12. The existence or aggravation of physical or mental infirmity, condition or disease, whether infectious, congenital, secondary or acquired in origin. Conditions or the aggravation of conditions that originated prior to the insured persons coverage under the policy.
13. Expense resulting from participating in activities for which benefits would be payable, in the absence of this insurance, under any high school or association catastrophe sports accident policy is expressly excluded under the policy.

PLEASE READ CAREFULLY:

You must indicate on the claim form the name of your personal insurance company and your policy number before benefits can be paid by the insurance plan. Failure to provide complete claim information will prolong payment of allowable benefits. Retain this description of coverage for your records. This is a brief description of the plan.

GROUP FOOTBALL OR GROUP ATHLETIC INSURANCE CLAIM FORM
 PLEASE READ CAREFULLY

CLAIM PROCESSING
 * * See Reverse Side * *

PART A
SCHOOL OFFICIAL TO COMPLETE

1) Name of School _____ Name of School System _____
 School Address _____
(Street) (City) (State) (Zip)

2. Name of Injured Student (Print) _____ Grade ____ Age ____
(First) (Middle) (Last)

3. Date of Injury _____ Time of Injury _____

4. Under whose supervision? _____ Title _____

5. The accident was incurred while the student was participating in:
 (check one) _____ Game _____ Practice _____ P.E. _____ Travel _____ Other _____

6. At the time of the injury, was the student involved in a school sponsored and supervised activity? _____ yes _____ no

7. Describe the accident fully. How did the accident happen?

Reported by: _____
(Signature of School Official) (Title) (Date)

PART B: PARENT/GUARDIAN STATEMENT

FATHER or GUARDIAN	MOTHER or GUARDIAN
Full Name _____ S.S.# _____	Full Name _____ S.S.# _____
Address _____ <small>(street)</small>	Address _____ <small>(street)</small>
_____ <small>(city) (state) (zip)</small>	_____ <small>(city) (state) (zip)</small>
Occupation _____ Employer _____	Occupation _____ Employer _____
Employer Address _____ <small>(street)</small>	Employer Address _____ <small>(street)</small>
_____ <small>(city) (state) (zip)</small>	_____ <small>(city) (state) (zip)</small>
Name & Address of Other Insurance Company _____	Name & Address of Other Insurance Company _____
Policy/Group No. _____ <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> HMO/PPO	Policy/Group No. _____ <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> HMO/PPO

KENTUCKY REQUIRED STATEMENT: 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.

1. I understand that I must furnish, with this claim, a statement from my personal insurance company indicating their allowable benefits or their reason for refusal to pay. I further understand this claim will remain pending until this information is provided.

2. I hereby authorize Reliance Standard Life Insurance Company to pay benefits (as provided by the policy) in connection with this accident direct to the doctor, and/or hospital rendering service unless I have checked below.
 _____ I do not authorize an assignment and request that benefits be paid directly to me.

3. I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose when requested to do so by Reliance Standard Life Insurance Company, or its representative, any and all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

4. I understand that I shall have a free choice of a physician or hospital for treatment. If, however, there is other valid coverage through another insurance plan and I do not choose a physician or hospital through the other plan, Reliance Standard Life will pay benefits as if the other plan's guidelines had been followed.

5. I certify that I have read and understand items 1- 4 (above) and I have read and understand the information on the reverse side of this form.

(Date) (Signature of Parent or Guardian)

PART C: FOR DENTAL INJURY

To be completed by dentist in the event of injury involving treatment to one or more teeth. Not to be used as a replacement for a copy of the actual itemized charges.

1. Identify injured teeth by tooth No. _____

2. Previous condition of injured teeth: Whole, sound, natural; Filled; Decayed; Root canal treated; Other (describe) _____

(Date) _____ Dentist's Name (Print) _____ Dentist's Signature _____

NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT THIS CLAIM FORM

IMPORTANT!!!

- Treatment Must Begin Within 30 Days From Date Of Accident
- Completed Claim Form Must Be Submitted Within One (1) Year From Date Of Accident
- All Treatment Must Be Received Within One (1) Year Of Accident

NOTE: TO SCHOOL PERSONNEL AND PARENTS

Our objective at Scholastic Insurors is to provide fast and accurate claims service. Listed below are instructions that, when followed, will assist us in providing this service.

WHEN TO FILE A CLAIM

1. Since the policy contains an **EXCESS MEDICAL EXPENSE BENEFIT**, YOU MUST FIRST FILE THE CLAIM WITH ANY OTHER INSURANCE (including major medical, HMO, PPO, Champus, etc.) so we may determine what payments, if any, we owe. *
2. The completed claim form and supporting documents must be received by Scholastic Insurors within one (1) year after the date of accident.

HOW TO FILE A CLAIM

1. Part A and Part B must be completed in full.
2. In the event the claimant sustained a dental injury, Part C must be completed in full by the dentist providing treatment.
3. Attach itemized bills showing the: (a) name of patient, (b) diagnosed condition, (c) date(s) of treatment, (d) nature of treatment, and (e) charge per treatment.
4. **SINCE THE POLICY CONTAINS AN EXCESS MEDICAL EXPENSE BENEFIT**, we also need:
 - A. Statement(s) from the other insurance company(ies) or plan(s) showing the payment(s) or rejection of the claim; or
 - B. If the insured has no coverage, a written statement from the insured's parent's employer(s) verifying there is no coverage for the insured.

WHERE TO FILE A CLAIM

Send all completed forms, itemized medical bills, etc., to:

SCHOLASTIC INSURORS, INC.
P.O. BOX 3194
JOHNSON CITY, TN 37602-3194
Telephone: 423-928-7381 Fax: 423-928-2761

**The insured shall have free choice of a physician or hospital for treatment. If, however, an insured has other valid coverage through another insurance plan(s) and does not choose a physician or hospital through the other plan, we will pay benefits as if the other plan's guidelines had been followed.*

GROUP PLANS

- COVERED EXPENSES -

	PLAN W	PLAN X	PLAN Y	PLAN Z
COVERED EXPENSES				
<u>Physician's</u> Surgery/fracture care fees Non-surgical visits or consultations Physical therapy	U & C (\$3,000 Max.) \$35/visit \$35/visit; Max. \$175	U & C (\$1,500 Max.) \$25/visit \$25/visit; Max. \$125	80% of U & C (\$1,500 Max.) \$20/visit \$20/visit; Max. \$100	60% of U & C (\$1,000 Max.) \$15/visit \$15/visit; Max. \$75
<u>Hospital</u> In-patient room and board In-patient miscellaneous charges Out-patient charges (non-surgical) Out-patient charges (surgical)	Semi-private room \$3,000/injury \$ 500/injury \$2,000/injury	Semi-private room \$1,500/ injury \$ 250/injury \$ 1,000/injury	Semi-private room \$1,000/injury \$ 150/injury \$ 500/injury	\$250/day of confinement (In-patient room & board + misc.) \$ 50/injury \$200/injury
<u>Diagnostic X-Rays, MRIs, CAT Scans</u>	\$400/injury	\$300/injury	\$250/injury	\$200/injury
<u>Dental</u> Amount payable for each injured sound, natural tooth	\$200	\$100	\$100	\$100
<u>Orthopedic Appliances</u>	\$100/injury	\$75/injury	\$50/injury	\$25/injury
<u>Ground Ambulance Service</u>	\$100/injury	\$75/injury	\$50/injury	\$25/injury
<u>Maximum Motor Vehicle Accident Benefit</u>	\$500/injury	\$500/injury	\$500/injury	\$500/injury

- NOTE:** 1. U & C for fracture care/surgery refers to the usual and customary fees established by the most current edition of the California Relative Value Study (X 130). Up to 25% of the surgeon's benefit paid for anesthetist and assistant surgeon.
2. Coverage is "secondary" to all other family insurance plans. Family insurance coverage, if any, must be considered first. Certain exclusions apply to these plans.
3. All medical, surgical, and dental treatment must begin within 30 days and be received within one year from the date of original accident.