2018-2019 PASCO COUNTY SCHOOL DISTRICT
INTERSCHOLASTIC SPORTS ACCIDENT INSURANCE SUMMARY

IMPORTANT NOTICE TO PARENTS OF PASCO COUNTY SCHOOL DISTRICT STUDENT ATHLETES

Your school is very interested in providing a safe environment for all students. However, accidents do happen every day during school activities. Therefore, the School Board of Pasco County purchases an interscholastic sports accident policy for student athletes. We strongly urge all parents to read this description of coverage in case an accident occurs during a sports practice or game. This policy may not pay for 100% of all medical expenses due to the limits of the policy as described below. The school cannot accept financial responsibility for any expenses due to interscholastic sports related injuries or any expense not covered by the school insurance policy.

The policy insures Senior High and Middle School student athletes and cheerleaders while they are participating in school supervised interscholastic sports practice sessions and games during the regular school term. Student athletes and cheerleaders are also protected during group travel in a school bus or van to and from the school and a covered interscholastic athletic event site. Travel in vehicles not owned or operated by the school is not covered.

Pasco student athletes injured while practicing for or competing in interscholastic sports during the regular school, as sanctioned by the Florida High School Athletic Association, may file for policy benefits. Pasco athletes that may be injured during off-season, school sponsored 'conditioning programs' that are scheduled and directly supervised by the school coach are also entitled to file for policy benefits. 'Conditioning' is defined as cardiovascular exercise or weight training. Weight training is the use of free weights and stationary apparatus. Cardiovascular conditioning is distance and interval training. Plyometrics is the use of pre-set conditioning programs. 'Conditioning' IS NOT teaching sport specific skills and drills, and DOES NOT involve the use of sport specific equipment (i.e. starting blocks, hurdles, rebounders, ball machines, bats, balls, rackets, etc.).
Injuries sustained during the summer or during any open gyms/facilities or camps <u>are not</u> covered by the Pasco sports policy. Off-season practices, drills or scrimmages are not covered under this plan. The coverage is effective during FHSAA sanctioned seasons as scheduled by FHSAA.

The School Sports policy is EXCESS INSURANCE. The policy will not allow anyone to profit by collecting duplicate benefits from several insurance sources. Any benefits that could be collected from any other insurance, PPO, HMO or other available source of coverage must pay first. If primary HMO or PPO coverage is available through your employer-sponsored plan, you should use the HMO or PPO approved doctors, hospitals and other providers for treatment of your child's injuries. If you do not use your available primary HMO or PPO networks, the school sports policy benefits will be reduced and you will be solely responsible for paying any unpaid medical bills not covered by the school sports policy.

<u>SPORTS POLICY MAXIMUM BENEFIT LIMITS</u>

The sports policy may not pay for all sports accident related medical expenses. **Some bills may exceed the limits of the policy. Visit www.schoolinsuranceofflorida.com for a listing of providers in your district.** The maximum policy benefits are listed below. For a claim to be considered eligible for policy benefits, an injured student must receive medical treatment by a licensed physician within ***sixty (60)*** days after the date of the original covered accident. The policy will pay for necessary, eligible medical treatment expenses that are rendered within 52 weeks after the date of a covered accident based upon the following policy limits:

HOSPITAL ROOM & BOARD: Semi-Private room rates of Pasco County Florida area hospitals.
INTENSIVE CARE ROOM & BOARD: *UCR not to exceed 7 days total or the maximum benefit.
HOSPITAL IN-PATIENT MISCELLANEOUS EXPENSE: not to exceed $7,000.00 for all in-patient charges including supplies, room charges, etc. **OUT-PATIENT EXPENSE AT A HOSPITAL OR A LICENSED AMBULATORY SURGERY CENTER:**
If minor surgery (repair of laceration, etc.) is performed or, if no surgery is performed: *UCR not to exceed $1,000.00;
If Major Surgery requiring anesthesia is performed: *UCR not to exceed $7,000.00.
SPECIAL DUTY NURSES: *UCR if hospital confined as an in-patient.
NON-SURGICAL VISIT, TREATMENT & CARE BY A PHYSICIAN: (a) 1st office visit or 1st visit at a hospital or ambulatory surgery center: $60.00 (b) subsequent non-surgical visits at physician's office: $40.00 (c)subsequent non-surgical visits at hospital: $60.00.
SURGERY AND ANESTHESIA BENEFITS FOR PRIMARY PHYSICIANS: The benefit amount listed in PART A of the 1997 Florida Worker's Compensation reimbursement manual. times a factor of 1.5.
SURGERY BENEFIT FOR ASSISTANT SURGEON: not to exceed 40% of benefit for primary physician; (payable only in the event that an assistant surgeon is necessary and required to perform the surgical procedure; Observation or Teaching is not considered a covered benefit).
PHYSIOTHERAPY: (Manipulation, Massage, Adjustments, Heat, Water, Electrical, etc.) $50.00 per day of out-patient treatment up to a maximum of $500.00 in the aggregate per covered accident.
DENTAL: up to $400.00 of treatment per sound, natural tooth that was injured in a covered accident.
X-RAY, RADIOLOGY (including reading fees): LABORATORY, EEG, EKG: $500.00 MAXIMUM; **MRI:** $700.00;
CAT OR OTHER SCANS: $400.00
AMBULANCE (AIR OR GROUND): $500.00
ORTHOPEDIC APPLIANCES (a cast or splint does not qualify): up to $600.00 if prescribed by a physician for rehabilitation purposes
DRUG STORE RX: up to $450.00
REPAIR OR REPLACEMENT OF EYEGLASSES, CONTACT LENS OR HEARING AIDS: up to $450.00 if loss is due directly to a covered accident causing bodily injury to a covered athlete or cheerleader.
ACCIDENTAL DEATH (must occur in 180 days of the accident): $5,000.00
ACCIDENTAL DISMEMBERMENT: (a) one member $10,000.00 (b) more than one member $20,000.00
MAXIMUM MEDICAL LIMIT PER COVERED ACCIDENT: up to $25,000.00 payable in the aggregate for a covered accident.

COVERED ACCIDENTS: The Sports policy provides benefits for covered claims due to sports accidents. A 'covered accident' is defined as a sudden, unforeseen, unexpected identifiable single event which results in accidental bodily injury to a covered athlete or cheerleader, independent of all other causes, occurring while the school policy is in force. Prolonged over-exertion or repeated injury due to non-accidental overuse is not considered a "covered accident". Policy benefits for heat exhaustion or fainting is provided if either occurs during or within one hour after participation in a school sports practice session or game.

PREFERRED PROVIDER NETWORK is a listing of medical service providers, doctors and hospitals, who have agreed to accept the school sports policy benefits as payment in full for services rendered in most cases. It is the parent's responsibility to pay any charges that are not covered by the school insurance plan. Not all doctors and hospitals accept the school insurance policy benefits as payment in full for services rendered. A listing of current **PREFERRED PROVIDERS can be reviewed at our website www.schoolinsuranceofflorida.com. NO PROFIT CLAUSE: The policy is EXCESS INSURANCE.** This means that any benefit payments that could be collected from any other insurance or similar plan must pay first. (If a person fails to follow rules of a PPO or HMO type plan and loses benefits that could have been collected, these benefits will be classified as collectible and the school insurance policy benefits will be reduced by the amount that could have been collected from the HMO or PPO). Total payment by all collectible insurance or plans shall never exceed the total reasonable medical expense incurred.

SURGERY as defined in the policy means (a) the repair of a laceration that requires sutures (b) any cutting operation, or (c) the reduction of a fracture or dislocation; (treatment of a non-displaced fracture not requiring reduction is not considered a surgical procedure).

SCHOOL SPORTS POLICY EXCLUSIONS

THE SPORTS ACCIDENT INSURANCE POLICY DOES NOT COVER:

1. Any injury not caused solely by participation in an FHSAA or middle school interscholastic sport scheduled by a Pasco County Florida Middle or Senior high school and under the direct supervision of a qualified school authority.
2. Hernia in any form, regardless of cause.
3. Injury caused by or while under the influence of alcohol or drugs unless prescribed by a licensed physician.
4. Mental illness or psychiatric evaluation or treatment expense.
5. Treatment performed by anyone retained by the schools or by any member of a covered person's immediate family.
6. Injury caused by participation in any type of open gym or private leagues and sports camps.
7. Aggravation of or re-injury of a pre-existing condition.
8. Travel between the School and the home premises of a covered person.
9. Any form of fighting or brawling or criminal or felonious assault or the Insured being engaged in an illegal occupation.
10. Any form of illness, sickness or disease including but not limited to the following: Pathological stress fractures; Perthes' Disease, Osgood-Schlatter's Disease, Osteomyelitis, Osteochondritis, Osteogenesis Imperfecta, Slipped Capital Femoral Epiphysis, Thrombophlebitis, Hysterical Reactions, Boils, Athlete's foot, impetigo or similar skin infection, rashes, poisonous vegetation reactions, warts, blisters, calluses, cramps, muscle spasms, allergies or allergic reactions, ingrown nails, appendicitis, infections occurring other than as a result of such injury, detached retina, or treatment expense for similar conditions not due to accidental bodily injury.
11. Expense resulting from participating in activities for which benefits would be payable, in the absence of this insurance, under any high school or association-sponsored catastrophe sports accident policy or trust fund is expressly excluded from coverage.
12. Any expense for which no benefit listed.

This description of insurance is not a contract and summarizes the Policy # 09-0103-2019 provisions, benefits and exclusions. Additional policy provisions and exclusions apply. Any difference between the policy and this description will be settled according to the provision of the Master Policy issued to the School Board.

HOW TO FILE A CLAIM

1) Obtain a claim form from the Coach or Athletic Director's Office. Instructions appear on the claim form. The Coach must completely fill in the school area, sign and date the form. It is the parent's total responsibility to make sure that the completed claim form is submitted to School Insurance of Florida's office within 90 days after the date of the accident. Claims will not be paid if received after 90 days from the accident date.

2) The school policy will not pay for any expense that can be obtained from any other valid form or primary insurance or coverage. It is the parent's total responsibility to file the claim with any other available insurance or valid source of coverage and then provide School Insurance of Florida with evidence of what primary insurance has paid. School sports policy benefits cannot be paid based upon 'balance due' statements. When your claim has been processed by your primary insurance, mail a copy of the explanation of benefits (EOB) received and all originals or copies of itemized bills and the claim form to *School Insurance of Florida*. Please visit our website for more information.

www.schoolinsuranceofflorida.com

Important Note: **Please do not leave the claim form with the Hospital or Doctor's Office. It is the parent's responsibility to make certain that the student's accident is reported to School Insurance of Florida no later than 90 days after the date of accident to be eligible for policy benefits.**

IF YOU HAVE CLAIM OR COVERAGE QUESTIONS CONTACT *SCHOOL INSURANCE OF FLORIDA*

Do not call the schools. The schools do not keep claim records and will not be able to answer claim questions.

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF ACCIDENT TO:

SCHOOL INSURANCE OF FLORIDA
P.O. BOX 784268
WINTER GARDEN, FL. 34778-4268
Telephone: Claims: 407-798-0290; 1-800-432-6915; Fax: 407-798-0296
www.schoolinsuranceofflorida.com

SCHOOL INSURANCE CLAIM FORM

CLAIM FORM AND NOTICE OF INJURY TO BE MAILED TO:
SCHOOL INSURANCE OF FLORIDA, P.O. BOX 784268, WINTER GARDEN, FLA. 34778-4268
The underwriting insurance company is Reliance Standard Life Insurance Co. Schaumburg, IL.

PARENTS: Policy limitations and exclusions are on the take home summary of insurance brochure. The Policy does not pay 100% of billed expense. It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This is ***'Excess Insurance***'. **Y**ou MUST file a claim with your primary insurance first. A school Official is required to fill out PART B only if the injury is school related. This form cannot be processed unless all questions are answered below and all signatures are in place. It is the duty of the claimant,(Parent/Legal Guardian), to furnish the company with itemized bills, explanation of primary insurance benefits paid, and this form completed. Visit School Insurance of Florida . Com for information regarding where to seek treatment and claim filing instructions. THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS AFTER DATE OF ACCIDENT. The policy allows for bills to be sent in for up to one year from the date of accident. **PLEASE DO NOT LEAVE THIS FORM WITH YOUR PHYSICIAN OR HOSPITAL.** It is the parent/guardian's responsibility to ask Doctors/ Providers what remaining balances you may be required to pay regarding this claim, if any.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A. Please print your answers.

1. Name of School: County: Grade:

2. Last Name of Student: First Name: Middle Initial:

3. Mailing Address of Parent: City: State: Zip:

4. Home Phone # ( ) - Date of Birth / /

5) **WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW, WHEN AND WHAT OCCURRED, THAT CAUSED THE INJURY. (Use back of this form if more space is needed).** How? What? When? Be specific please.

_____

_____

_____

6. **INJURY DATE:** Month_____Day_____Year_____Time_____ AM or PM - Where did the accident happen?_____

If this is sports related what is the name of the team or camp?_____

7. Nature of Injury or sickness (indicate part of body injured-such as broken arm, sprained ankle etc…) _____

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this line blank).
Other insurance includes but is not limited to the following: HMO's, PPO's BC/BS, United, Employer Benefits, ERISA, Medicaid, Welfare or Government Trust accounts, or Tri-care. **It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This policy will not pay for 100% of billed charges.** What is deductible or co-pay (if any)? $_____

If you have a Medicaid plan please send a copy of your insurance card with this form.

9. Address of claims office of insurance company on line 8._____

10. Mother's Name and Employer:_____Occupation:_____

Mother's Employer Address:_____Telephone #_____

11. Father's Name and Employer:_____Occupation:_____

Father's Employer Address:_____Telephone #_____

****The above answers are true and correct. I hereby authorize any person or institution to release any information requested by the insurance company or its agent to them, including history and physical, diagnosis or other medical or insurance information. A photo static copy of this authorization shall be considered as effective and valid as the original. **FLORIDA LAW:** "Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree."*

PARENT/
12. GUARDIAN SIGN HERE:_____ Today's Date:____/_____/_____Print Name: _____

PART B - Must be filled out and signed by a School Official for ALL school sports related injuries. Must be filled out for all other school related injuries unless the student purchased the 24 Hour Plan.

1. WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW THE ACCIDENT OCURRED THAT CAUSED THE INJURY. Please be specific. (Use back of this form if more space is needed.)

_____

_____

2. Injury Date: Month_____Day_____Year_____Time_____AM or PM Part of body injured (include whether right or left)_____

3. At the time of the injury was the student involved in a school sponsored, funded, scheduled and supervised activity? YES NO

Please select or list the interscholastic sport or activity the student was participating in. Circle One.
P.E. Class - Football Game - Football Practice - Soccer - Volleyball - Baseball - Softball - Track - Wrestling - Flag Football - Competitive Cheerleading - Rugby Lacrosse-- Side line Cheerleading - Basketball OTHER LIST _____

4. Under whose supervision(witness)?_____ What date has the Athlete returned to play if applicable? ____/____/_____

5.Print Name of School Official _____School phone Number:_____-_____-_____

6.**Original Signature of School Official** _____(Only if injury is School Related) Today's Date:____/_____/_____

Please DO NOT LEAVE THIS FORM with the Doctor or Hospital. Mail to School Insurance of Florida immediately upon completion.

PART C: ATTENDING PHYSICIAN OR DENTIST STATEMENT. Itemized bills are required to determine the eligibility of a claim. **If the provider is going to bill us directly you do NOT need to have PART C completed.**

1. Diagnosis and Concurrent conditions. Explain any complications._____

2. Date you first treated the sickness or injury____/____/_____ Dates of subsequent treatment: _____

3. When did the symptoms first appear? Date: _____

4. Were your services necessary solely because of the incident described in part A(front)? YES NO Is treatment completed? YES NO

5. Did any previous injury, sickness or impairment contribute to this injury? YES NO If yes, explain details._____

_____

6. Did x-ray show fracture? YES NO If fracture or dislocation, state whether reduced or immobilized and what the procedure was?

_____CPT/CRVS_____

7. Physician's Degree (M.D.,etc.)_____ Print name of physician or dentist: _____

8. Federal tax ID# (or Soc. Sec. #) _____ **(Benefits cannot be paid to you without this).**

9. Address of physician or dentist. STREET NUMBER_____

CITY_____STATE_____ZIP CODE_____ ***Signature of physician or dentist***: _____

10. FOR DENTAL CLAIMS ONLY: Indicate which teeth were involved in the accident? _____
11. Describe condition of injured teeth prior to accident: **Circle conditions:**
Filled--- Capped--- Artificial--- chipped--- broken--- crowned- damaged--- abscessed---Otherwise Fitted--- Whole, sound and natural--- Other_____

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

1) You must file your claim with your other (Primary) insurance company first. Other insurance include, but not limited to: HMO's, PPO's BC/BS, United, Employer Benefits, HSA's or Tri-care***. This is secondary coverage*** and may not pay for 100% of medical expenses incurred. When your claim has been processed by your primary insurance; mail a copy of the explanation of benefits (EOB's), the itemized bills to *School Insurance of Florida.* **We cannot accept a balance due statement, itemized bills are required.** ***Important note***: **Please do not leave the claim form with the Hospital or Doctor's Office.** Participants can seek treatment from any licensed provider of service. **It is the participants responsibility to find out what out of pocket expenses they could incur. Please ask your provider of service if they are in your primary network. Visit School Insurance of Florida .Com for provider information.**

2) **A completed School Insurance of Florida Claim Form must be submitted within *90 days* from the date of the incident**. If the condition is school related or happened at school Part B must be completed. If the condition did not happen at school complete Part A and mail directly to School Insurance of Florida. For additional information please contact School Insurance of Florida 1-800-432-6915.

3) The plan administrator mailing address is: **School Insurance of Florida**
P.O Box 784268
Winter Garden, FL. 34778-4268

Reasons claims are delayed for processing: **1**. Claim Forms Not Completed In Full or Not Submitted. **2**. Balance Due Statements, Balance Forward Statements, or Past Due Statements submitted instead of the correct Medical Itemized Bills (UB-04/92 or HCFA-1500) which are standard forms used by providers of service or Doctors. **3**. Explanation of Benefits from Primary Insurance Carrier not provided with the correct bills.

If we do not receive your reply within 45 days, we will close our file. However, upon receipt of the requested information, we will reopen the file and process your claim in accordance with the policy provisions.

ADDITIONAL
COMMENTS:_____

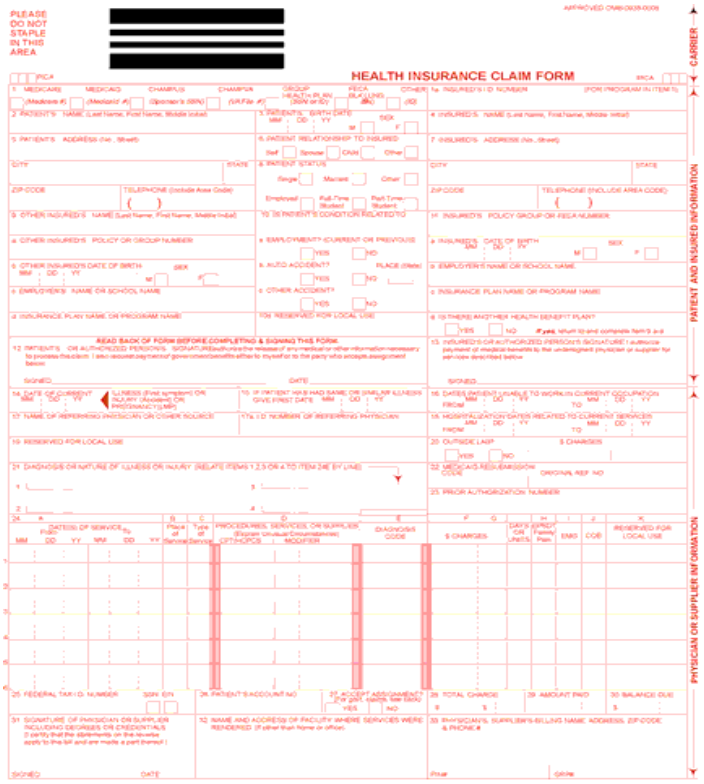
_____

_____

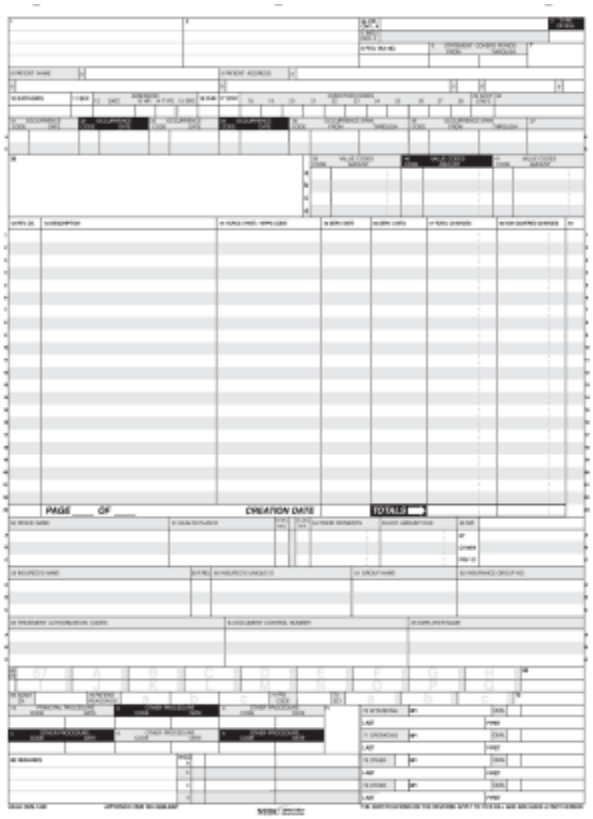
_____

This is a sample of an itemized bill. Balance due statements or summary of accounts are not itemized bills. Please submit itemized bills so we may promptly review claims.

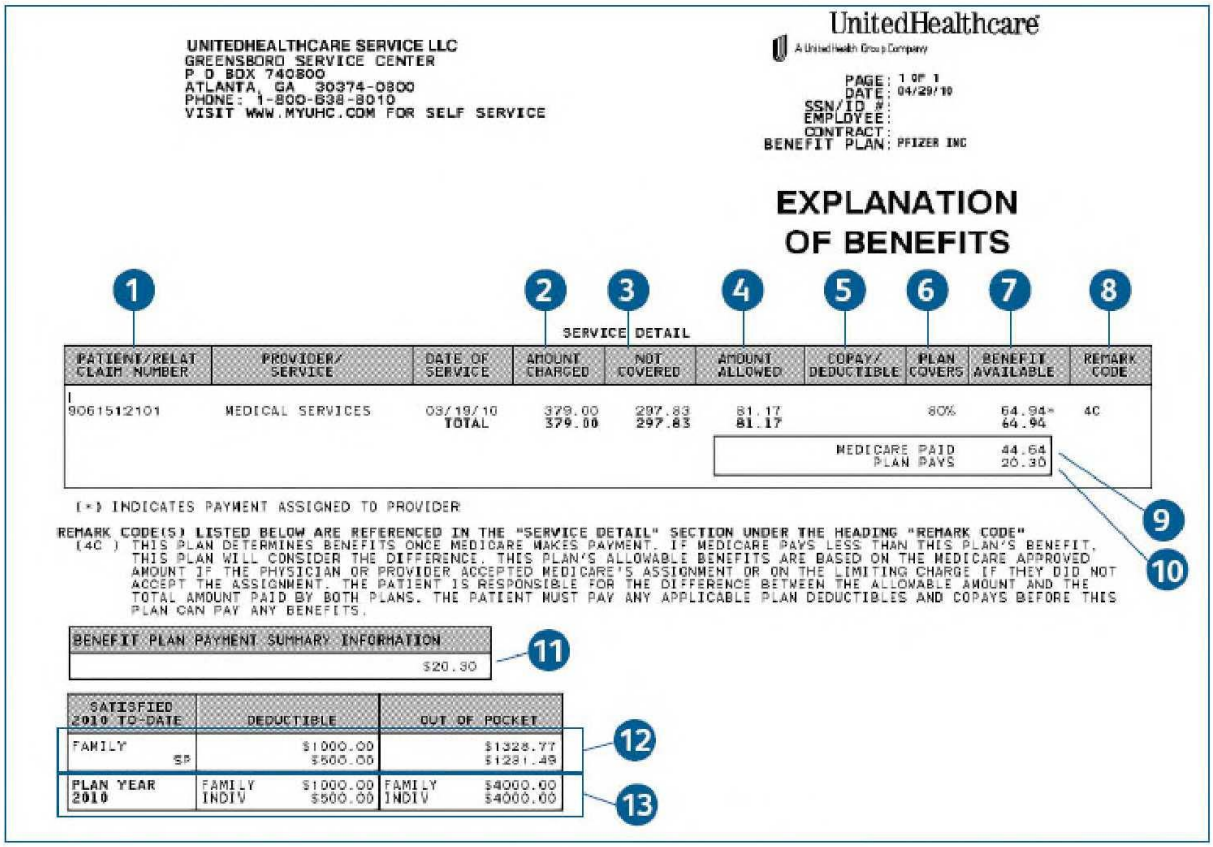
SAMPLE HCFA 1500



SAMPLE UB-04



SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPAY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
		TOTAL	379.00	297.83	81.17			64.94	
							MEDICARE PAID	44.64	
							PLAN PAYS	20.30	

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE		OUT OF POCKET	
FAMILY	$1000.00		$1328.77	
SP	$500.00		$1281.48	
PLAN YEAR 2010	FAMILY INDIV	$1000.00 $500.00	FAMILY INDIV	$4000.00 $4000.00