IMPORTANT DOCUMENT
BOYD COUNTYSCHOOLS
GROUP ALL SCHOOL ACCIDENT INSURANCE PROGRAM
2014-15

TO: Parent/Guardian:

All Boyd County students are covered by Scholastic Insurors, Inc., for bodily injury at school, while participating in any school sponsored activity, athletic or otherwise, or while traveling to or from school or such activity. The insurance plan provided by the Boyd County Schools **does not** pay 100% of all medical and dental expenses (**See Limitations**). Please note that the insurance provided by the Boyd County Schools is "secondary" to other family insurance plans and will pay only the eligible medical expenses not payable by other insurance sources. *Following is information outlining the benefits and limitations of the school purchased plan.*

BENEFITS

If accidental bodily injury occurs while participating in a school sponsored and supervised activity 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 for the services and supplies as listed below (see **LIMITATIONS** below) for necessary medical, dental or hospital care provided **within one year from the date of the 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.

MEDICAL TREATMENT MUST COMMENCE WITHIN 30 DAYS.
** NOTE ** SUBMIT A COMPLETED CLAIM TO SCHOLASTIC INSURORS WITHIN 90 DAYS FROM THE DATE OF ACCIDENT. ** NOTE **
MEDICAL BENEFITS AVAILABLE FOR ONE YEAR FROM DATE OF INJURY.
NO MEDICAL BENEFITS AVAILABLE AFTER ONE YEAR FOLLOWING THE DATE OF INJURY

LIMITATIONS

- Hospital Room and Board (Semi-Private Room Rate)
- Hospital Out-patient charges – Non surgical ($150 max per injury)
- Physician's surgery/fracture care fees (80% of U & C - $1,500 max/injury)
- Physical Therapy ($20/visit; $100 max per injury)
- Ground Ambulance ($50 max per injury)
- Diagnostic x-rays, MRI's, CAT Scans ($250 max per injury)
- Hospital Inpatient miscellaneous charges ($1,000 max per injury)
- Hospital Out-patient charges – Surgical ($500 max per injury)
- Physician's non-surgical visits or consultations ($20/visit)
- Dental ($100 per tooth)
- Orthopedic Appliance ($50 max per injury)

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.

FA&AS-B

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
- Please Note: The Accident Insurance Plan Has Exclusions and Benefit Limitations. The Insurance Plan May Not Pay 100% For All Expenses

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.*

AS-00

SCHOLASTIC INSURORS, INC.
P. O. Box 3194, Johnson City, TN 37602-3194

GROUP ALL SCHOOL 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_____
(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

Full Name_____ S.S.#_____

Address_____
(street)

_____
(city) (state) (zip)

Occupation_____ Employer_____

Employer Address_____
(street)

_____
(city) (state) (zip)

Name & Address of Other Insurance Company_____

_____

Policy/Group No._____
☐ Group ☐ Individual ☐ HMO/PPO

MOTHER or GUARDIAN

Full Name_____ S.S.#_____

Address_____
(street)

_____
(city) (state) (zip)

Occupation_____ Employer_____

Employer Address_____
(street)

_____
(city) (state) (zip)

Name & Address of Other Insurance Company_____

_____

Policy/Group No._____
☐ Group ☐ Individual ☐ 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 the above information.

_____ _____
(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_____