

**ACCIDENT ONLY INSURANCE POLICY  
SCHEDULE OF BENEFITS  
GREENVILLE COUNTY SCHOOLS  
MANDATORY MIDDLE AND HIGH SCHOOL ATHLETICS COVERAGE**

**Persons Covered:** The insurance shall cover on a blanket basis all middle school and high school athletes, team managers and cheerleaders in the play or practice of interscholastic athletics under the supervision of a regularly employed coach or trainer or qualified adult school authority of the policyholder. Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the above mentioned interscholastic athletic competitions. Spring training, off-season workouts and play-off games as defined and sanctioned by the state interscholastic governing body are included under this coverage.

The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of \$25,000 for each Injury. Provided that medical treatment begins within 30 days from the date of the Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of the Injury up to the maximum benefit per service as scheduled below.

**INPATIENT**

Room & Board:	Usual and Customary Charges
Intensive Care:	Usual and Customary Charges
Hospital Miscellaneous:	\$750 first day/\$375 each subsequent day
Registered Nurse's Services:	Usual and Customary Charges
Physician's Visits:	\$40 per day/\$750 maximum

*(Benefits are limited to one visit per day and do not apply when related to surgery)*

**OUTPATIENT**

Day Surgery Miscellaneous:	\$1,500 maximum
<i>(Usual &amp; Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index)</i>	
Physician's Visits:	\$40 per day/\$750 maximum
<i>(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)</i>	
Physiotherapy:	\$40 per day/10 days maximum
<i>(Benefits are limited to one visit per day)</i>	
Emergency Room:	\$500 maximum
<i>(Use of room and supplies, treatment must be rendered within 72 hours from time of Injury)</i>	
X-Rays:	\$300 maximum
MRI/Cat Scan:	\$600 maximum
Laboratory:	\$300 maximum
Injections:	No Benefits
Prescription Drugs:	Usual and Customary Charges
Orthopedic Braces & Appliances:	\$500 maximum

**INPATIENT AND/OR OUTPATIENT**

Surgeon's Fees:	80% of Usual and Customary Charges/\$2,500 maximum
<i>(Specified surgery based on data provided by Ingenix, Inc) (No more than one procedure through the same incision will be paid)</i>	
Anesthetist/Assistant Surgeon:	25% of surgery allowance
Ambulance:	\$500 maximum/Air Ambulance maximum is \$1,000
Consultant:	No Benefits
Dental:	\$400 per tooth
<i>(Benefits paid on Injury to Sound, Natural Teeth Only)</i>	
Replacement of Eye Glasses, Contact Lenses or Hearing Aids:	\$500
<i>(When due to a covered Injury)</i>	
Motor Vehicle Injury:	Paid as any other Injury/\$10,000 maximum

Ingenix Inc. assigns a relative unit value to each listed procedure based on its complexity and performance time. When benefits are paid according to this Schedule, the number of units assigned to a procedure is multiplied by the coefficient value to arrive at the benefits payable. Usual and Customary Charges are based on data provided by Ingenix, Inc. using the 75<sup>th</sup> percentile.

*This is a brief illustration of coverage offered through the K12 Student Athletic and Accident Insurance.  
The Master Policy issued will be the contract and will govern and control the payment of benefits.  
The Policy is a non-renewable one year term policy.  
The policy contains an Excess Provision. No benefits are payable for expense incurred that is paid or payable by other valid and collectible insurance.*

**Underwritten By:**  
United Healthcare Insurance Company

**Administered By:**  
Health Special Risk, Inc.  
P.O. Box 117558 ♦ Carrollton, TX ♦ 75011-7558  
(866) 409-5734 ♦ (972) 512-5820 FAX  
[www.k12studentinsurance.com](http://www.k12studentinsurance.com)

## POLICY EXCLUSIONS AND LIMITATIONS

**Benefits will not be paid for: a) loss or expense caused by, contributed to, or resulting from: or b) treatment, services or supplies for, at, or related to:**

1. Air travel except while as a fare-paying passenger on a regularly scheduled commercial air carrier; travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limited to: two or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; snowmobile or off-road motorized vehicle not requiring licensing as a motor vehicle.
2. Artificial aids such as eyeglasses, contact lenses, hearing aids, or examinations or prescriptions therefore unless specifically provided for in the Schedule of Benefits.
3. Cosmetic surgery of any kind, except reconstructive surgery as a direct result of a covered Injury.
4. Dental treatment, except for accidental Injury to Sound, Natural Teeth.
5. Food poisoning or bacterial infections (except an infection occurring through an open visible wound); cysts or skin lesions such as blisters or boils; tumors; over-exerting; fainting; hernia, regardless of how caused; illness or disease in any form.
6. Immunizations; preventive medicines or vaccines, except where required for treatment of a covered Injury.
7. The addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
8. Injury for which benefits are paid or payable by worker's compensation or employer's liability or occupational disease law.
9. Injury where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
10. Nuclear reactions or radiation contamination; war, declared or undeclared (a pro-rata premium will be refunded upon request for such period not covered); participation in a riot or civil disorder; or while a member of the Armed Services.
11. Orthodontics (braces) for any reason or damage to or loss of orthodontics.
12. Pre-existing Conditions or aggravation of a Pre-existing Condition.
13. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of injury.
14. Skiing, scuba diving, surfing, roller skating, riding in a rodeo.
15. Skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planning, bungee jumping, bob-sledding, or ballooning.
16. Suicide or attempt thereat, while sane or insane (including drug overdose); intentionally self-inflicted Injuries; fighting.
17. Supplies, except as specifically provided in the policy.
18. While committing or attempting to commit an assault or felony, or to which a contributory cause was the Covered Persons being engaged in an illegal occupation.

**Pre-Existing Condition** means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Covered Person's Effective Date under the policy; or 2) any condition which is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Covered Person's Effective Date under the policy.

**Injury** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; and 4) sustained while the Covered Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

## EXCESS INSURANCE PROVISION

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for injury which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy. Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed as a result of the Covered Person's failure to comply with policy provisions or requirements. Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

## HOW TO FILE A CLAIM

NOTE: Medical Treatment must be received from a qualified licensed Physician within 30 days from the date of accident.

1. Obtain a claim form quickly from our website or from your school office or call UnitedHealthcare **StudentResources** at 866-409-5734. Answer all questions in detail and include signatures to avoid claim from being returned for incomplete information.
2. Attach all bills to the completed form and mail to the insurance company within 90 days of the accident.
3. Any bills not filed with the claim form should be sent to the company identified with the student's name, school district, and date of accident. Bills that cannot be attached to the initial form must be submitted within 90 days of the date of service. Bills submitted after one year will not be considered for payment except on the absence of legal capacity.

## ACCIDENTAL DEATH AND DISMEMBERMENT

If such Injury shall independently of all other causes and within 180 days from the date of accident solely result in any one of the following specific losses, the Covered Person or beneficiary may request the Company to pay the applicable amount below in lieu of payment under the "Medical Expense Benefits" provision.

Loss of Life .....	\$10,000.00
Loss of Both Hands, Both Feet, or Sight of Both Eyes .....	\$10,000.00
Loss of One Hand and One Foot .....	\$10,000.00
Loss of Either One Hand or One Foot and Sight of One Eye .....	\$10,000.00
Loss of One Hand or One Foot or Sight of One Eye .....	\$ 5,000.00
Loss of Entire Thumb and Index Finger of Either Hand .....	\$ 500.00