

**ACCIDENT ONLY INSURANCE POLICY**  
**SCHEDULE OF BENEFITS**  
**THE SCHOOL BOARD OF MIAMI-DADE COUNTY**  
**INTERSCHOLASTIC FOOTBALL PROGRAM**  
**Policy # 2010-201912-1**

**Eligibility:** Any player who participates in interscholastic tackle football (both fall football and spring football). Accidents during play and practice of interscholastic football begins with the first session for those players who pay the appropriate premium on or before practice begins. Otherwise, coverage begins on the day premium is paid to the School Site Athletic personnel. Coverage ends for the fall season after the last game of the season including post season games and All Star games. Spring football coverage terminates after the last day of the 20 sessions allowed by the Florida High School Athletic Association. The policy also covers accidents that occur while traveling to play a game with another school while riding in a vehicle that is under physical supervision or proper authority of the School Board. Coverage is extended to include pre and post season conditioning at the school site that is under physical supervision or proper authority of the School Board

The Policy provides for loss due to a covered Injury up to the Maximum Benefit of \$25,000 for each Injury and a Deductible of \$250 for each Injury. Provided that the treatment begins within **60 days** from the date of the Injury, benefits will be paid for Covered Medical Expenses incurred within **104 weeks** from the date of Injury up to the maximum benefit per service as scheduled below. Any service or supply not specifically listed is not covered.

**Maximum Benefit:** \$25,000 per Injury  
**Deductible:** \$250 per Injury  
**Inpatient**  
Room & Board: \$1,000 per day maximum  
Hospital Miscellaneous: Paid under Room & Board  
Nurse's Services: Usual & Customary Charges  
Physician's Visits: \$45 first day / \$40 each subsequent day  
*(Benefits are limited to one visit per day and do not apply when related to surgery)*

**Outpatient**  
Day Surgery Miscellaneous: Usual & Customary Charges  
*(Usual & Customary Charges are based on the Florida Workers Compensation Fee Schedule.)*  
Physician's Visits: \$45 first day / \$40 each subsequent day  
*(Benefits are limited to one visit per day and benefits for Physicians visits do not apply when related to surgery or physiotherapy)*  
Physiotherapy: \$30 per day maximum / 20 visits maximum  
Medical Emergency: Usual & Customary Charges  
*(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)*  
X-Rays: \$75 maximum  
CAT Scan: \$375 maximum  
MRI: \$750 maximum  
Laboratory: No Benefits  
Injections: No Benefits  
Prescription Drugs: Usual & Customary Charges  
Orthopedic Braces & Appliances: Usual & Customary Charges

**Inpatient and/or Outpatient**  
Surgeon's Fees: Usual & Customary Charges  
*(Specified Surgery based on the Florida Workers Compensation Fee Schedule).  
(No more than one procedure through the same incision will be paid)*  
Anesthetist/Assistant Surgeon: Usual & Customary Charges  
Ambulance: \$250 maximum  
Consultant: Usual & Customary Charges  
Dental: \$500 per tooth / \$1,000 maximum per Injury  
*(Benefits are paid on Injury to Sound, Natural Teeth Only)(Includes orthodontia as a result of a covered Injury)(The exclusion for orthodontics will be waived)*  
Dental X-Rays: \$15 one tooth / \$40 full mouth  
Eye Glasses, Contact Lenses, and Hearing Aid Replacement: Usual & Customary Charges  
Hearing Aids: Paid under Orthopedic Brace & Appliances  
*(When due to a Covered Injury) (The exclusion for hearing aids will be waived)*  
Home Health Care: 40 visits maximum  
*(Services must be rendered within 7 days after hospital stay or outpatient surgery. Physician must recommend treatment and treatment must be certified buy the Utilization Review Program.)*  
Motor Vehicle Injury: \$2,000 maximum *(other than 2 or 3 wheeled)*

**Waiver of \$250 Deductible** occurs if: (1) Necessary surgery is performed on an outpatient basis; (2) Diagnostic laboratory or X ray services are performed on an outpatient basis for pre-admission testing within 7 days prior to hospital admission; or (3) A mandatory second surgical option is obtained for the necessity of non-emergency surgery; this waiver applies only to charges for a second opinion.

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 is the contract and will govern and control the payment of benefits.*

*The policy contains an Excess Provision. No benefits are payable for expense incurred that is paid or payable by other valid and collectible insurance.*

*The Policy is a non-renewable one year term policy.*

**PRIVACY POLICY**

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of our nonpublic personal information. You may obtain a detailed copy of our privacy practices by calling us toll-free at (866) 313-4512 or by visiting us at [www.k12studentinsurance.com](http://www.k12studentinsurance.com)

**Facts About The Policy:**

1. The Master Policy on file with the school district is a non-renewable one year term policy.
2. This is a limited benefit policy.

THIS IS A LIMITED POLICY. THE BENEFITS OUTLINED ARE THE MAXIMUM LIABILITY TO BE PAID BY THE COMPANY AND IN NO WAY ARE MEANT TO REFLECT THE TRUE VALUE OF TREATMENT. WHEN ANY TYPE OF EXPENSES PAYABLE UNDER THIS POLICY EXCEEDS \$500, THIS POLICY WILL PAY ONLY IN EXCESS OF OTHER VALID AND COLLECTIBLE INSURANCE.

**Underwritten By:**  
UnitedHealthcare 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 or 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 for which benefits are paid by the prior insurer to the extent of its accrued liability and extension of benefits or benefit period as required by F.S. 627.667.
- 10. 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).
- 11. 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.
- 12. Orthodontics (braces) for any reason or damage to or loss of orthodontics.
- 13. Pre-existing Conditions or aggravation of a Pre-existing Condition.
- 14. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of injury.
- 15. Skiing, scuba diving, surfing, roller skating, riding in a rodeo.
- 16. Skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planing, bungee jumping, bob-sledding, or ballooning.
- 17. Suicide or attempt thereat, while sane or insane (including drug overdose); intentionally self-inflicted Injuries; fighting.
- 18. Supplies, except as specifically provided in the policy.
- 19. 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 any condition which manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months immediately prior to the Covered Person's Effective Date under this 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.

**EXTENSION OF BENEFITS AFTER TERMINATION**

The coverage provided under this policy ceases on the Termination Date. However, if a Covered Person is Totally Disabled on the Termination Date from a covered Injury, Covered Medical Expenses for such Injury will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

Totally Disabled means the Covered Person's inability to engage in most normal activities of a person of like age and sex in good health.

**BENEFITS FOR OUTPATIENT SERVICES**

Benefits will be provided for treatment performed outside of a Hospital for any Injury as defined in the policy provided that such treatment would be covered on an inpatient basis and is provided by a health care provider whose services would be covered under the policy if the treatment were performed in a Hospital. Treatment of the Injury must be a Medical Necessity and must be provided as an alternative to inpatient treatment in a Hospital. Reimbursement is limited to amounts that are Usual and Customary for the treatment or services.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

**BENEFITS FOR PROCEDURES INVOLVING BONES OR JOINTS OF THE JAW AND FACIAL REGION**

Benefits will be paid the same as any other Injury for diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is medically necessary to treat conditions caused by Injury.

Benefits shall be subject to all Deductive, copayment, coinsurance, limitations, or any other provisions of the policy.

**HOW TO FILE A CLAIM**

NOTE: Medical Treatment must be received from a qualified licensed Physician within 60 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.
- 4. If you have other insurance, file simultaneous claims with your other insurance carrier and UnitedHealthcare StudentResources, to avoid a delay in benefit payments.

**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.....	\$1,000
Loss of Both Hands, Both Feet, or Sight of Both Eyes .....	\$1,000
Loss of One Hand and One Foot.....	\$1,000
Loss of Either One Hand or One Foot and Sight of One Eye.....	\$1,000
Loss of One Hand or One Foot or Sight of One Eye.....	\$ 500
Loss of Entire Thumb and Index Finger of Either Hand.....	\$ 500