INSURANCE

The Rockingham County Schools Board of Education has purchased accident insurance for athletes. The description below is not the official insurance contract but a summary of the benefits. The policy is underwritten by United Healthcare Insurance Company. The policy number is 2009-111742-1

Who Is Covered?

All athletes in grades 7-12 are covered while practicing for, competing in or traveling to and from as representative of the school and under the direct supervision of a coach, in any athletic activities under the regulations and jurisdiction of the school.

Medical Payments ($0.01 - $25,000)

If the accident covered by the policy requires treatment of an athlete within 30 days after the date of the injury by licensed physician, or hospital confinement, the company will pay the expensed incurred as listed below which are determined by the company to be reasonable and customary in the geographical area where the services is rendered, for necessary medical, dental or hospital care incurred within one year from the date of the injury up to a maximum of $25,000 for any one accident, subject to the "Excess Provision".

"Excess Provision" is defined as reimbursement by other valid insurance. This means that the athlete's family medical insurance will pay the claim and then the athletic insurance will pay the balance up to the limits of the policy listed on the next page.

Summary Of Benefits For Athletic Insurance

Maximum Benefit	**$25,000 for each injury**
Deductible	**$0.00**
Inpatient Services	
Room & Board	**Semi-private room rate/ $150 per day**
Hospital Miscellaneous	**$100 first day**
Registered Nurse	**75% of Usual & Customary Charge**
Physician's Visits	**$40 first day/$25 each subsequent day**
Outpatient Services	
Day Surgery Miscellaneous	**$1,000 maximum (Usual & Customary Charges for Day surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index)**
Physician's Visits	**$25 per day**
Physiotherapy	**$10 per day/ 5 days maximum**
Emergency Room	**$100 maximum**
X-Rays	**$200 maximum**
CAT Scan/MRI	**$300 maximum**
Laboratory	**$50 maximum**
Prescription Drugs	**$75 maximum**
Orthopedic Braces & Appliances	**$75 maximum**

Inpatient and/or Outpatient Services	
Surgeon's Fee	**$1,000 maximum**
Anesthetist	**20% of amount paid for surgery**
Ambulance	**$100 maximum**
Dental	**$200 per tooth**

Exclusions and Limitation

Benefits will not be paid for loss due to:

- **Air travel except while as a fare-paying passenger on a regularly schedule 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.

- **Artificial aids such as eyeglasses, contact lenses, hearing aids, or examinations or prescriptions therefore unless specifically provided for in the Schedule of Benefits.**
- **Cosmetic surgery of any kind, except reconstructive surgery as a direct result of a covered injury.**
- **Dental treatment, except for accidental injury to sound, natural teeth.**
- **Immunizations; preventive medicines or vaccines, except where required for treatment of a covered injury.**
- **Food poisoning or bacterial infection (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.**
- **Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenic, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the covered person's physician.**
- **Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers; compensation insurance carrier according to a final adjudication under the NC Workers' Compensation Act or an order of the NC Industrial Commission approving a settlement agreement under the NC Workers' Compensation Act.**
- **War, declared or undeclared; voluntary participation in a riot or civil disorder; or while a member of the Armed Services.**
- **Orthodontics (braces) for any reason or damage to or loss of orthodontics.**
- **Pre-existing conditions or aggravation of a pre-existing condition.**
- **Routine physical examination or routine testing; preventive testing or treatment; screening exams or testing in the absence of injury.**
- **Skiing, scuba diving, surfing, roller skating, riding in a rodeo.**

- **Skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planning, bungee jumping, bob-sledding or ballooning.**
- **Suicide or attempt thereat, while sane or insane (including drug overdose); intentionally self-inflicted injuries; fighting.**
- **Supplies, except as specifically provided in the policy.**
- **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.**

Catastrophic Insurance:

This plan will pay 100% of the eligible Reasonable and Customary Medical and Dental expenses incurred for medically necessary services and supplies after the deductible of $25,000 has been satisfied. All eligible expenses must be incurred within 260 weeks of the date of the injury.

How To File A Claim For An Athletic Injury:

1. **Student <u>MUST</u> see a doctor with 30 days of the injury.**
2. **Claim form must be sent with in 90 days of the date the person received medical care.**
3. **Obtain a claim form from the school's athletic director or trainer or see the section for forms on this Websites.**
4. **All lines must be completely filled out and be sure to sign the Medical Authorization.**
5. **The school official must sign the bottom of the form to certify that the accident occurred as stated.**
6. **If you have other applicable insurance, you must also file with that company. When you receive your Explanation of Benefits (EOB) which shows what your insurance company has paid, forward a copy of these to the address below.**
7. **Once the claim form, itemized bills, and the EOB has been received, the insurance company can process you claim.**
8. **Remember…Filing a claim after an injury is the PARENT'S responsibility.**

SEND YOU CLAIM FORM TO:

United Healthcare Student Resources
P.O. Box 809027
Dallas, TX 75380-9027

What do you do if you have a problem with the student insurance?

If you have completed the 8 steps above and still have not heard from the Untied Healthcare Insurance Company, you may call the Insurance Administrator, Lawrence Braxton at 1-800-232-9601.

School Accident Insurance

School Accident Insurance – Parents may purchase Student Accident Insurance from the same company as the school system uses to cover the athletes. Brochures are distributed to student at the opening of schools and when a new student enrolls. The policy has many options for coverage and the cost starts at $9.00 and goes to $157.00.

Claims are filed by the parent which is explained below with a Claim Form which may be printed from on line and mailed to the company.

Student Claim Form
UnitedHealthcare StudentResources
P.O. Box 809027
Dallas, TX 75380-9027
(888) 251-6160

School District: Rockingham County Schools
City and State: 511 Harrington Hwy, Eden, NC 27288
School Name:
Policy Number: 2009-111742

Student's Last Name **Student's First Name** **Student's Nickname** (If Applicable)

Date of Birth **Grade**

Name of Parent/ Legal Guardian		**Address Street/ PO Box**	
City		**State**	**Zip Code**

WHAT OTHER INSURANCE COMPANY/COMPANIES PROVIDE COVERAGE THAT WOULD COVER THIS CLAIM?

Name of Company(s) **Name of Insured**

If NO Other Insurance, Sign Here

STATEMENT BELOW MUST BE SIGNED WHEN TREATMENT REQUIRES SURGERY OR HOSPITAL CONFINEMENT.

I hereby authorize the hospital or doctors involved to give UnitedHealthcare StudentResources all information regarding the insured's condition, including the history obtained, findings and diagnosis. A photocopy of this form shall be considered as valid as the original.

Date **Signature of Parent or Legal Guardian**

I authorize payment directly to my medical provider(s) for charges for this claim. I understand that I am financially responsible for all charges not covered by this authorization.

Date **Signature of Parent or Legal Guardian**

DESCRIBE ACCIDENT/ILLNESS IN DETAIL

Date of Injury **Time of Injury** ◯ **AM** ◯ **PM** **Date of First Treatment**

Place of Injury **Name of Person Supervising the Activity**

Which Best Describes the Activity:

- ◯ **P.E Class**
- ◯ **Athletic Period**
- ◯ **On School Property during**
- ◯ **During Lunch Hr**
- ◯ **School Sponsored Activity during school hours**
- ◯ **Not School Related**
- ◯ **A Spectator**
- ◯ **Traveling to/from school**
- ◯ **In School Bus**
- ◯ **School Sponsored Field Trip**

Describe how injury happened or the nature of an illness?

If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

What part of the body was injured?

REPORTS OF AT-SCHOOL OR ATHLETIC INJURIES MUST BE CERTIFIED BY A SCHOOL OFFICIAL

I hereby certify that the above named student was insured under the UnitedHealthcare StudentResources Plan at the time of the accident and I believe the accident occurred as stated herein.

Date **Parent or Legal Gardian** **School Official**

TO ASSURE TIMELY PROCESSING OF YOUR CLAIM, PLEASE VERIFY ALL THE QUESTIONS ABOVE ARE ANSWERED. ATTACH ITEMIZED BILLS, PAID RECEIPTS, EXPLANATIONS OF BENEFITS, AND ALL RELEVANT DOCUMENTS TO THIS CLAIM FORM.

THE FOLLOWING NOTICE IS APPLICABLE TO ANY STATE NOT INDIVIDUALLY LISTED BELOW
ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE SUBJECT TO CRIMINAL AND/OR CIVIL PENALTIES.
AK - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
AZ – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
AR - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
CA – For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
CO – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance.
DE – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
DC – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
FL - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
ID – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
IN – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
KY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.
LA - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance*is guilty of a crime and may be subject to fines and confinement in prison.
ME - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
MN – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH – Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NM - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
NY - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
PA - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.
TN - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
TX – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
VA - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

HOW TO FILE A CLAIM FORM

THIS CLAIM FORM MUST BE SENT WITHIN 90 DAYS OF THE DATE YOU FIRST RECEIVED MEDICAL CARE. IF YOU DID NOT SIGN THE REVERSE SIDE TO PAY BENEFITS TO PROVIDER, YOU MUST INCLUDE ORIGINAL RECEIPTS FOR EACH PAID BILL. KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

PLEASE FOLLOW THESE INSTRUCTIONS:

1. All lines must be completely filled out and be sure to sign the Medical Authorization.

2. Send **ORIGINAL ITEMIZED BILLS** with diagnosis and the corresponding **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**. (Keep copies for your records) **BALANCE FORWARD STATEMENTS ARE NOT SUFFICIENT.**

3. Mail completed form to: UnitedHealthcare **Student**Resources, P. O. Box 809027, Dallas, TX 75380-9027.

4. Attach itemized bill to completed claim form. An itemized bill must include:
   a. School District name
   b. Patient's name
   c. Patient's complete address
   d. Diagnosis
   e. Date of service(s)
   f. Description of treatment (i.e. type of x-ray, office visit, lab test, etc.). Including CPT (procedure) codes
   g. Doctor's/Hospital name, address and telephone number

5. Please do not send bills without a completed claim form. The bills will not be processed with partial information.