

HAMBLEN COUNTY SCHOOLS

STUDENT ACCIDENT INSURANCE- - - 2017-18

Attention Parents/Guardians

We suggest you consider purchasing this accident insurance for your child(ren). Even if you have a family insurance plan, this accident insurance plan will help pay your co-payments and deductibles for medical and dental expenses.

CHOICE OF PLANS

(Benefit limitations and exclusions of these plans are stated in this information)

	ANNUAL PREMIUMS			
<p style="text-align: center;">SCHOOL – TIME ONLY PLAN</p> <p>Accident Insurance While - - -</p> <ul style="list-style-type: none"> • Attending regular school sessions • Participating in school-sponsored extra-curricular activities • Traveling directly to and from school for (a) regular school sessions, (b) school sponsored extra-curricular activities while under the supervision of a school employee • participating in school-sponsored interscholastic sports except Senior High tackle football 	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">REGULAR Benefits Plan ➔\$8</td> </tr> <tr> <td style="text-align: center;">DOUBLE Benefits Plan ➔\$16</td> </tr> <tr> <td style="text-align: center;">TRIPLE Benefits Plan ➔\$24</td> </tr> </table>	REGULAR Benefits Plan ➔\$8	DOUBLE Benefits Plan ➔\$16	TRIPLE Benefits Plan ➔\$24
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<p style="text-align: center;">24-HOUR PLAN <u>WITHOUT</u> EXTENDED DENTAL BENEFITS</p> <p>Accident Insurance - - -</p> <ul style="list-style-type: none"> • 24 hours a day until the beginning of next school year • While at home, at school, on vacation • While participating in sports, including amateur sports, except Senior High tackle football 	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">REGULAR Benefits Plan ➔\$44</td> </tr> <tr> <td style="text-align: center;">DOUBLE Benefits Plan ➔\$88</td> </tr> <tr> <td style="text-align: center;">TRIPLE Benefits Plan ➔\$132</td> </tr> </table>	REGULAR Benefits Plan ➔\$44	DOUBLE Benefits Plan ➔\$88	TRIPLE Benefits Plan ➔\$132
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<p style="text-align: center;">24-HOUR PLAN <u>WITH</u> EXTENDED DENTAL BENEFITS</p> <p>Provides the same 24-hour a day protection as described above plus <i>Extended Dental Benefits</i>.</p> <p><i>Extended Dental Benefits</i> Provides - - -</p> <ul style="list-style-type: none"> • Up to \$400 per injured tooth • Extended dental benefit period from one year to 2 years • Benefits for covered dental accidents – not for orthodontic services or dental diseases 	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">REGULAR Benefits Plan ➔\$49</td> </tr> <tr> <td style="text-align: center;">DOUBLE Benefits Plan ➔\$98</td> </tr> <tr> <td style="text-align: center;">TRIPLE Benefits Plan ➔\$147</td> </tr> </table>	REGULAR Benefits Plan ➔\$49	DOUBLE Benefits Plan ➔\$98	TRIPLE Benefits Plan ➔\$147
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<p style="text-align: center;">HIGH SCHOOL FOOTBALL PLAN</p> <p>Covers the student while practicing for or competing in school-sponsored interscholastic senior high tackle football, with grades 10-12, including travel directly and uninterrupted to or from such practice or competition.</p> <p>(Coverage effective for pre-season and regular season games and playoffs)</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">REGULAR Benefits Plan ➔\$40</td> </tr> <tr> <td style="text-align: center;">DOUBLE Benefits Plan ➔\$80</td> </tr> <tr> <td style="text-align: center;">TRIPLE Benefits Plan ➔\$120</td> </tr> </table>	REGULAR Benefits Plan ➔\$40	DOUBLE Benefits Plan ➔\$80	TRIPLE Benefits Plan ➔\$120
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DOUBLE Benefits Plan ➔\$80				
TRIPLE Benefits Plan ➔\$120				

EFFECTS OF OTHER COVERAGE:

The policy will provide benefits in addition to and regardless of other collectible insurance. See other parts of this information for limitations and exclusions. No deductible applies to this policy.

BENEFITS FOR *REGULAR PLAN**

DOCTOR – HOSPITAL – DENTAL EXPENSES

- DOCTOR VISITS IN OFFICE OR HOSPITAL – Pays up to \$15.00 for the initial physician's visit; up to \$10.00 for each necessary follow-up hospital or office visit.
- SURGERY – Pays 60% of the "usual and customary" (as defined below) physician's expenses up to an aggregate maximum of \$1,000.00 per injury.
- INPATIENT HOSPITAL SERVICE – Pays up to an aggregate maximum of \$150.00 per day.
- HOSPITAL OUTPATIENT SERVICES – When not confined in a hospital, services rendered by and within a hospital shall be covered to a maximum of \$60.00 per injury, which includes all visits to the hospital for the same injury.
- X-RAY SERVICE – Pays up to \$10.00 per x-ray not to exceed 4 x-rays per injury, including reading. (When rendered by doctor or hospital as outpatient)
- AMBULANCE – To and from the hospital, benefits shall not exceed \$25.00 per injury.
- DENTAL TREATMENT - \$100.00 per tooth for repair or replacement of each injured sound natural tooth. See optional extended dental benefits outlined in this brochure.
- PHYSIOTHERAPY, DIATHERMY, OR SIMILAR TREATMENT – Diathermy, ultrasonic, whirlpool or heat treatments, adjustment, manipulation, massage or any form of physical therapy and/or office visit connected therewith, expenses shall not exceed \$10.00 per visit not to exceed 5 visits.
- MOTOR VEHICLE – Benefits shall not exceed \$500.00 per accident – two or three wheeled motor vehicle injuries not covered. See Exclusions 7 and 11.
- CASTS & BRACES – Pays up to \$25.00 per injury when prescribed and necessitated in conjunction with a covered accident.
- EYEGLASSES REPLACEMENT – Pays up to \$25.00 per injury when prescribed and necessitated in conjunction with a covered accident.

*** DOUBLE & TRIPLE BENEFITS OFFER: If you desire a plan that provides twice the benefits or triple the benefits as listed above, pay the "Double Benefits Plan" price or the "Triple Benefits Plan" price instead of the "Regular Benefits Plan" price.**

When injury covered by this policy results in treatment by a Licensed Physician within 30 days from the date of injury, the company will pay the usual and customary expenses for the services and supplies as listed above actually incurred within one year from the date of injury to a maximum of \$100,000 per injury for the 24 Hour Plans and a maximum of \$25,000 per injury for the School Time Only Plans. "Injury" means loss resulting from accidental bodily injury caused directly by an accident, independent of other causes and sustained while the policy is in force. The "usual and customary" charges shall be the allowable charges as set forth in the Revised California Relative Value Studies using a \$100.00 per unit conversion factor for surgery. Benefits for assistant surgeon's fees and anesthesiologist's fees shall be limited to 25% of the allowable surgery benefit.

TO FILE A CLAIM: Notify school officials immediately. Obtain a claim form from the school. Submit the claim along with bills within 90 days of the date of accident.

RETAIN THIS DESCRIPTION OF COVERAGE FOR YOUR RECORDS. This is a brief description of the plan benefits. The exact provisions governing the insurance are contained in the master policy FORM LRS-8975et al, issued to the Policyholder by Reliance Standard Life Insurance Co. A sample policy is available upon request to the Administrator. Any provision of the policy or the brochure which is in conflict with the statutes of the state in which the policy is issued, will be administered to conform with the requirements of the state statutes. Keep your cancelled check or money order receipt as evidence of payment. This insurance has scheduled benefits.

LIMITATIONS and EXCLUSIONS

The plans do not cover the following:
Treatment expense due to:

1. The practice or play for interscholastic football including travel to or from such practice or play (a) if the student is enrolled in the 10th, 11th, or 12th grades, or (b) if the student is enrolled in the 9th or lower grade and is participating in practice or play with students enrolled in the 10th, 11th, or 12th grades unless the premium for such coverage has been paid.
2. Contact lenses or hearing aids; damage to other than whole, sound, vital, and natural teeth or to existing dental bridges, crowns, restorations or braces; orthodontic procedures and services; drugs, injections, miscellaneous supplies and medications except while hospital confined.
3. 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, hernia of any kind, however caused; infections occurring other than as a result of such injury; detached retina; or psychiatric care.
4. Any form of illness, sickness, or disease including but not limited to the following: Perthes' Disease, Osgood-Schlatter's Disease, Osteomyelitis, Osteochondritis, Osteogenesis Imperfecta, Slipped Capital Femoral Epiphysis, Thrombophlebitis, Hysterical Reactions, or similar conditions.
5. Fighting and Brawling; any form of criminal or felonious assault or the insured's being engaged in an illegal occupation.
6. 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.
7. 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 collectible from other valid coverage will be payable up to \$500.00 in the aggregate.
8. Intentionally self-inflicted injury. War or any act of war.
9. 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.
10. Aviation in any form except while the Covered Person is riding as a passenger in a licensed airplane provided by an incorporate passenger carrier on a regularly scheduled passenger flight and route.
11. 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.
12. The use of or while under the influence of drugs or intoxicants unless administered as prescribed by a physician.
13. 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 person's coverage under the policy.
14. 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 from coverage under the policy.

**ADDRESS INQUIRIES
AND CLAIMS TO
ADMINISTRATOR:
SCHOLASTIC INSURORS, INC.
P. O. BOX 3194
JOHNSON CITY, TN 37602-3194
(423) 928-7381**

**INSURED BY:
RELIANCE STANDARD LIFE
INSURANCE COMPANY
2001 Market Street, Suite 1500
Philadelphia, PA 19103**

**ACCIDENTAL DEATH AND
DISMEMBERMENT BENEFITS**

Occurring within 180 days from date of accident. The policy pays the eligible medical expense or largest applicable amount set forth below, whichever is greater.

Accidental Death
\$1,000.00
Accidental Loss of Both
Hands, Feet, or Eyes
\$10,000.00
One Hand and One Foot
\$5,000.00
Either Hand or Foot
\$3,750.00
Sight of One Eye
\$1,000.00

HOW TO ENROLL:

1. Fill Out the **ENROLLMENT FORM** and make *check* or *money order* payable to: **SCHOLASTIC INSURORS**
 2. Mail the **ENROLLMENT FORM** with premium to: **SCHOLASTIC INSURORS, P. O. Box 3194, Johnson City, TN 37602** (Please write the student's name on your *check* or *money order*.)
- If you have any questions, contact Scholastic Insurors at (423) 928-7381**

RETAIN THIS DESCRIPTION OF COVERAGE FOR YOUR RECORDS. This is a brief description of the plan benefits. The exact provisions governing the insurance are contained in the master policy.

-----detach here-----

ENROLLMENT FORM			ACCIDENT INSURANCE CHECK (✓) YOUR SELECTION(S) Annual Premiums			
Student's Name - Please Print!			BENEFIT CHOICES			
First Name	Middle Initial	Last Name	PLANS	REGULAR Benefits Plan	DOUBLE Benefits Plan	TRIPLE Benefits Plan
Address _____			SCHOOL -TIME ONLY PLAN	\$8.00 <input type="checkbox"/>	\$16.00 <input type="checkbox"/>	\$24.00 <input type="checkbox"/>
City _____ State _____ Zip Code _____			24-HOUR PLAN (WITHOUT EXTENDED DENTAL BENEFITS)	\$44.00 <input type="checkbox"/>	\$88.00 <input type="checkbox"/>	\$132.00 <input type="checkbox"/>
Name of School Student Attends _____			24-HOUR PLAN (WITH EXTENDED DENTAL BENEFITS)	\$49.00 <input type="checkbox"/>	\$98.00 <input type="checkbox"/>	\$147.00 <input type="checkbox"/>
Names of School System <u>HAMBLÉN COUNTY SCHOOLS</u>			HIGH SCHOOL FOOTBALL PLAN (PLAYERS PARTICIPATING WITH GRADES 10-12)	\$40.00 <input type="checkbox"/>	\$80.00 <input type="checkbox"/>	\$120.00 <input type="checkbox"/>
* Signature of Parent or Guardian _____ Date _____			TOTAL PAYMENT ENCLOSED	\$ _____	\$ _____	\$ _____

NOTE: Coverage becomes effective on the date premium is received by SCHOLASTIC INSURORS.