

FAIRFAX COUNTY SCHOOLS ATHLETIC ACCIDENT INSURANCE

2008-2009

If your child participates in a sport sponsored by the Fairfax County Schools and you have no insurance coverage you will need to purchase one of the coverages explained on this flyer. This is an **EXCESS POLICY** and will pay for only those covered charges in excess of expenses paid by any other insurance up to the maximums shown below. Even if you do have other insurance, this would help with co-pays and expenses not covered by your primary insurance.

MEDICAL BENEFITS - If a student receives treatment by a legally qualified physician or surgeon (other than a member of the family) or is hospital confined, and treatment begins within 60 days from the date of injury, the Company will PAY THE USUAL AND CUSTOMARY CHARGES incurred for medical, dental or hospital care SUBJECT TO the provisions of the option plan selected, limitations and exclusions outlined on this flyer. Expenses incurred after 52 weeks from the date of injury are not covered, even though the service is a continuing one or one that is necessarily delayed beyond one year from the date of injury.

OPTION	LOW	MIDDLE	HIGH
Maximum Benefits (for each Injury)	\$25,000	\$25,000	\$25,000
<u>INPATIENT</u>			
Hospital Room & Board	\$150 per day	80% of U & C Semi-Private	80% of U & C Semi-Private
Hospital Inpatient Miscellaneous	\$100 per day	\$1,200 per day	80% of U & C
Registered Nurse's Services	75% of U & C	U & C	80% of U & C
Physician's Visits	\$40 first day \$25 each subsequent day	\$60 first day \$40 each subsequent day	80% of U & C
(Benefits are limited to one visit per day and do not apply when related to surgery)			
<u>OUTPATIENT</u>			
Day Surgery Miscellaneous	\$1,000 maximum	\$1,200 per day	80% of U & C \$5,000 max
(U & C for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index)			
Physician's Visits	\$25 per day	\$60 1st day \$40 each subsequent day	\$50 per day
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)			
Physiotherapy	\$10 per day 5 day maximum	\$60 first day \$40 each subsequent day 5 day maximum	\$50 per day 15 day max
(Benefits are limited to one visit per day)			
Emergency Room	\$100 maximum	\$300 maximum	80% of U & C
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)			
X-rays	\$200 maximum	\$600 maximum	80% of U & C
CAT Scan/MRI	\$300 maximum	\$600 maximum	80% of U & C \$1,200 max
Laboratory	\$50 maximum	\$300 maximum	80% of U & C \$600 max
Prescription Drugs	\$75 maximum	\$200 maximum	U & C
Orthopedic Braces & Appliances	\$75 maximum	\$140 maximum	80% of U & C
<u>INPATIENT AND/OR OUTPATIENT</u>			
Surgeon's Fee	\$1,000 maximum	\$1,200 maximum	80% of U & C \$5,000 max
(Specified surgery based on data provided by Ingenix, Inc.) (No more than one procedure through the same incision will be paid)			
Anesthetist/Assistant Surgeon	20% of surgery allowance	25% of surgery allowance	30% of surgery allowance
Ambulance	\$100 maximum	\$800 maximum	80% of U & C
Consultant	\$100 maximum	\$400 maximum	80% of U & C
Dental	\$200 per tooth	\$500 per tooth	80% of U & C
(Benefits are paid on injury to Sound, Natural Teeth Only)			
Replacement of eyeglasses, contact Lenses and hearing aids	\$200 maximum	\$300 maximum	\$600 maximum
(As a result of a Covered Injury)			

ACCIDENTAL DEATH, DISMEMBERMENT & LOSS OF SIGHT:

Benefits are paid for losses which are incurred within 180 days from date of injury. The following benefits are paid in addition to the medical benefit:

Loss of Life	\$10,000
Loss of one hand, one foot, or sight in one eye	\$ 5,000
Loss of both hands, both feet or sight in both eyes	\$10,000
Loss of Entire Thumb and Index Finger	\$ 500

DEFINITIONS:

Pre-Existing Condition means any condition 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 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.

VIRGINIA 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 vehicles; 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, 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 any drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Persons' 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. 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. Play or practice of interscholastic high school football; except where a specific additional premium is paid.
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, 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.

UNDERWRITTEN BY: **UNITED HEALTHCARE INSURANCE COMPANY**

MARKETED BY: **FIRST SERVICE INSURANCE, INC.**
19 Roberts Ave.
Windsor, VA 23487
(757) 483-4100 (800) 422-7722 FAX: (757) 483-9063

**FAIRFAX COUNTY SCHOOLS
FIRST SERVICE INSURANCE, INC.
ATHLETIC ACCIDENT INSURANCE
2008-2009**

If you wish to purchase this insurance, please complete the application and return it to your school's certified athletic trainer.

	<u>Low Option</u>	<u>Middle Option</u>	<u>High Option</u>
At School only	_____ \$9.00	_____ \$15.00	_____ \$25.00
At school w/dental	_____ \$16.00	_____ \$22.00	_____ \$32.00
24-Hour only	_____ \$45.00	_____ \$75.00	_____ \$150.00
24-Hour w/dental	_____ \$52.00	_____ \$82.00	_____ \$157.00
Varsity Football w/at school	_____ \$94.00	_____ \$165.00	_____ \$240.00
Varsity Football w/at school/dental	_____ \$101.00	_____ \$172.00	_____ \$247.00
Varsity Football w/24 hour	_____ \$130.00	_____ \$225.00	_____ \$365.00
Varsity Football w/24 hour/dental	_____ \$137.00	_____ \$232.00	_____ \$372.00

School District Fairfax County Public Schools School Name _____

Name of Child _____

Date of Birth _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Signature of Parent/Guardian _____ Date _____

Attach check made payable to **United HealthCare** and return to **YOUR SCHOOL'S CERTIFIED ATHLETIC TRAINER.**

ATHLETIC TRAINER: Please send to: First Service Insurance, Inc., 19 Roberts Ave., Windsor, VA 23487