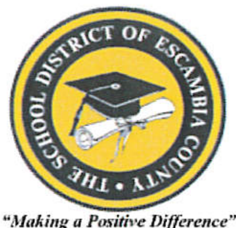

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
75 NORTH PACE BOULEVARD
PENSACOLA, FL 32505
PH (850)432-6121 FX (850)469-6379
http://escambiaschools.org
KEITH LEONARD, SUPERINTENDENT

July 27, 2023

Dear Parents/Guardians of Middle School Athletes:

The School District provides for an "Excess Blanket Athletic Insurance Policy" that will provide accidental medical coverage for students injured while participating in District sanctioned extra-curricular athletic activities. The District requires that all students trying out for or competing in school district sponsored athletics remain covered by a medical insurance policy at all times. The District pays the entire premium for this "Blanket Policy" that provides uniform coverage for all athletes without risk of cancellation due to loss or ineligibility for continued coverage. This policy can provide valuable insurance coverage for parents that either do not have insurance, or those parents that have existing coverage under either a **"private"** (UHC, Blue Cross, Humana, Aetna, etc...) or **"public"** (Tricare, Medicaid, Champus, etc...) medical insurance plan. For parents who have existing insurance, this "Excess Plan" will pay for many out-of-pocket expenditures (co-pays, deductibles, coinsurance, etc...) based on the attached "Schedule of Benefits".

This policy is secondary coverage for students who are already covered by a **"private"** family policy but shall be primary coverage for the students who have no other insurance coverage, or are covered by a **"public"** family policy. Athletes are covered by this Excess Blanket Policy while participating in extra-curricular athletics under school sponsorship and supervision; and while being transported by approved district transportation. A description of the plan (schedule of values) including policy exclusions and limitations can be found attached to this letter or from your coach. ***The School District shall not be responsible for costs of treating injuries or assume liability for any other costs associated with an injury while participating in extra-curricular athletic activities including, but not limited to, out-of-pocket medical expenses.***

The policy is issued through Mutual of Omaha Insurance Company and claims will be administered by Health Special Risk, Inc. If you have any questions concerning the policy, claims, or coverage you may contact them at 1-866-409-5734, or visit them on-line at www.healthspecialrisk.com.

For parents with existing medical insurance coverage with a private or public insurance carrier, you will still need to provide your coach with a copy of your existing medical insurance card in the event that your child needs medical treatment and to assist with the filing of claims (primary or secondary coverage).

In addition, parents will be required to complete or have completed the District required forms prior to try-outs or any participation in athletic activities. Visit the District's Athletics website for:

- All required athletic participation forms at: Middle School Forms

We appreciate the opportunity to serve your student and student athletes in Escambia County and we are pleased to provide you with this valuable "blanket policy" for the 2023-24 school year. If you have any questions concerning the insurance program, please contact Kevin Windham, Director of Risk Management, at (850)469-6162 or you may also contact your school's head coach or principal.

Please let us know if you have any questions or if we can assist you in any way.

Sincerely,

Keith Leonard

KL/KW/dh

July 2023

Dear Parents:

The School District of Escambia County has chosen Mutual of Omaha Insurance Company to provide insurance coverage for all Middle School and High School Interscholastic Athletics for the 2023/2024 school year. ***Health Special Risk, Inc. (HSR)*** will be the policy and claims administrator for Mutual of Omaha, the same administrator for the past 10 years.

This insurance plan provides coverage on a secondary/excess basis and pays after any other coverage you may have. If you have no other coverage, this plan pays as primary coverage.

Please read through the benefits attached to this letter. This plan is not meant to pay 100% of the bills. Note the benefit limits within the policy. The maximum benefit is $25,000 for each injury.

Also attached to this letter is a claim form which includes instructions for filing a claim. Only one claim form per injury is needed. Coaches and Athletic Directors will be responsible for completing the school's portion of the claim form in the event of an injury. Once the school's portion of the claim form is completed, parents are then responsible for having the remainder of the claim form completed, attaching the doctor's bill, Explanations of Benefits (EOB's) from your primary insurance company and submitting it to the address on the claim form.

If you have claim questions, please call **1-866-409-5734 Toll-Free from 8:00 AM to 5:00 PM.** Thank you for your continued support.

Parents are urged to keep this letter and attachments on file in the event of an injury during the year.

SERVICE PROVIDED BY:

Health Special Risk, Inc.
HSR Plaza II
8400 Belleview Dr, Suite. 150, Plano, Texas 75024
(972) 512-5600
cassandratalton@hsri.com
www.healthspecialrisk.com

SCHOOL DISTRICT OF ESCAMBIA COUNTY
MIDDLE SCHOOL AND HIGH SCHOOL ATHLETICS COVERAGE
Accident Only Insurance Policy – Schedule of Benefits – SR2014FLLG-P-100330
Claims Administered by *Health Special Risk, Inc. (HSR)*

Persons Covered:

The insurance shall cover on a blanket basis all middle school and high school athletes in the play or practice of interscholastic athletics while under the supervision of a regularly employed coach or trainer or qualified adult school authority of the policyholder. This coverage includes 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 and coaching staff supervised off season, off premises High School Football conditioning camps are included under this coverage.

The Policy provides for loss due to a covered Injury up to the Maximum Benefit of $25,000 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 **52 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.

Inpatient

- Room & Board: Semi-private room rate/$150 per day
- Hospital Miscellaneous: $600 per day
- Registered Nurse's Services: 75% of Usual & Customary Charges
- Physician's Visits: $40 first day/$25 each subsequent day *(Benefits are limited to one visit per day and do not apply when related to surgery)*

Outpatient

- Day Surgery Miscellaneous: $1,000 maximum *(Usual & Customary Charges are based on the Outpatient Surgical Facility Charge Index.)*
- Physician's Visits: $40 first day/$25 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 first day/$20 each subsequent day/5 days maximum *(Benefits are limited to one visit per day)*
- Emergency Room: $150 maximum *(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)*
- X-Rays: $200 maximum
- Cat Scan/MRI: $300 maximum
- Laboratory: $50 maximum
- Injections: No Benefits
- Prescription Drugs: $75 maximum
- Orthopedic Braces & Appliances: $75 maximum
- Durable Medical Equipment (*post surgical only*): $150.00 maximum

Inpatient and/or Outpatient

- Surgeon's Fees: $1,000 maximum *(Specified Surgery based on data provided by Ingenix, Inc.) (No more than one procedure through the s0jwame incision will be paid)*
- Anesthetist/Assistant Surgeon: 20% of Surgery Allowance
- Ambulance: $300 maximum

- Consultant: $200 maximum
- Dental: $200 per tooth *(Benefits are paid on Injury to Sound, Natural Teeth Only)*
- Replacement of Eye Glasses, Contact Lenses Or Hearing Aids: $200 maximum *(As a result of a Covered Injury)*

- *Usual and Customary Charges are based on data provided by Ingenix, Inc. using the 75th percentile.*
- *Benefits will be provided as required by the State of Florida for Extension of Benefits after Termination if the Covered Person is Totally Disabled,*
- *This is a brief illustration of coverage offered through the K12 Student Athletic and Activities 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.*

POLICY EXCLUSIONS AND LIMITATIONS

No coverage is provided for:

1. Injuries resulting from air travel except while as a passenger for transportation only; operating, sitting or riding 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. The cost of dental treatment, except for accidental Injury to Sound, Natural Teeth.
3. Injuries received while under the influence of any controlled substance, unless administered on the advice of a physician.
4. Injuries received as a result of being intoxicated (as determined and defined by the laws in the jurisdiction which the loss or cause of loss was incurred; for the purposes of this exception, the laws governing the operation of motor vehicles while intoxicated will apply to any activity occurring at the time of the accident).
5. Expenses for which benefits are paid or payable by Worker's Compensation or employer's liability law.
6. 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).
7. Injuries caused by an act of war, declared or undeclared
8. Re-injury or complications of a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 6 month period preceding the effective date of individual insurance.
9. Injuries received while skiing, scuba diving, surfing, roller skating, riding in a rodeo.
10. Injuries received while skydiving, parachuting, hang gliding, glider flying, flight in an ultra light aircraft, parasailing, sail planing, bungee jumping, bob-sledding, or ballooning.
11. Suicide or attempt thereat, while sane or insane; injuries received while fighting or brawling (except in self-defense).
12. Injuries received while traveling except as described in the policy.

Injuries mean accidental bodily injuries: (a) received while insured under this policy; and (b) resulting independently of sickness and all other causes.

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. Benefits are payable for any expense which is not recoverable from any other insurance policy or service contract.

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. **All claims need to be first filed with any primary insurance inforce such as the injured student's parent's group medical insurance.**
2. **Obtain a claim form quickly from our website www.healthspecialrisk.com; from your school office or call *Health Special Risk, Inc. (HSR)* toll free at 1-866-409-5734.**
3. **Answer all questions in detail and include signatures to avoid claim from being returned for incomplete information.**
4. **Attach all ITEMIZED BILLS (NOT "Balance Due" statements) AND copies of your primary insurance company's "Explanation of Benefits" (EOB) detailing the payments made by them to the completed form and mail to *HSR* as soon as possible.**
5. **Any bills not filed with the claim form should be sent to *HSR* 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 60 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 Speech and Hearing $10,000.00
- Loss of One Hand or One Foot or Sight of One Eye $5,000.00
- Loss of Speech or Hearing $5,000.00
- Loss of Entire Thumb and Index Finger of Either Hand $500.00

Underwritten by:

Mutual of Omaha Insurance Company, Omaha, Nebraska

Claims Administered by:

***Health Special Risk, Inc.,* Carrollton, Texas**

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail, E-mail or Fax to *HSR*

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734
E-mail : K12claims@hsri.com

School District: ______

School Name: ______

Student ID #: ______

Policy Number: ______

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail

6. Address of Injured Person	7. Phone Number (include area code)
8. Parent/Legal Guardian Name, Address, City, State & Zip	9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:

	☐ During lunch hour	☐ Athletic period
☐ Play or practice of interscholastic sports	☐ In school bus	☐ On school property during school hours
☐ Not school related	☐ School sponsored field trip	☐ School sponsored activity during school hours
☐ P.E. class	☐ Traveling to/from school	☐ ROTC activity

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

Signature of Parent/Legal Guardian: X Date:	Signature of School Official: X Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company ______ Policy # ______

Name of insurance company ______ Policy # ______

If applicable, claimant's primary employer name, address, and phone number ______

If applicable, mother's primary employer name, address, and phone number ______

If applicable, father's primary employer name, address, and phone number ______

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian: X Date:	Signature of Witness: X Date:

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE ______ **DATE** ______

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE ______ **DATE** ______

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.