2015/2016 STUDENT ATHLETIC/ACCIDENT INSURANCE

	Watkins Ins		TX Student Resources	TX Student Resources	TX Student Resources	TX Student Resources	TX Student Re
	PLAN A		PLAN B	PLAN C	PLAN D	PLAN E	PLAN F
Company Name	80% U&C-Plan-Current			Columbian Life	Columbian Life	Mutual of	Mutual of
	Catlin		Liberty Insur	Life Insur	Life Insur	Omaha	Omaha
	Catlin		Underwriters	TX Star Plan	TX Value Plan	Premier Plan	Premier Plus
PREMIUM	50,700		45,921	34,350	49,050	33,489	41,313
CATASTROPHIC	2,062		2,585	2,268	2,268	2,506	2,506
TOTAL	$52,762		$48,506	$36,618	$51,318	$35,995	$43,819
max benefit	7,500,000		7,500,000	7,500,000	7,500,000	7,500,000	7,500,000
benefit period	10 years		10 years	10 years	10 years	10 years	10 years
cash benefit	500,000		500,000	500,000	500,000	500,000	500,000
	in network/zero billing		in network/zero billing	in network/zero billing	in network/zero billing	in network/zero billing	in network/zer
	in question		2 networks	2 networks	2 networks	2 networks	2 networks
voluntary plan	Standard	Elite	Economy/Premier	No UIL/UIL	No UIL/UIL	Economy/Premier	Economy/Prer
at school	20/30	30/50	64/94	25/115	25/115	64/94	64/94
24 hour plan	35/90	45/100	128/196	105/195	105/195	128/196	128/196
extended dental	included	included	9/9	9/9	9/9	9/9	9/9
Football only	275	n/a	189/291	325	325	189/291	189/291
Spring Football	n/a	n/a	76/116	n/a	n/a	76/116	76/116

Claims Paid

	2008-2009	$23,424
	2009-2010	$22,445
	2010-2011	$26,713
	2011-2012	$40,525
	2012-2013	$30,899
	2013-2014	$25,991
Projected	2014-2015	$65,205

PLAN A

CATLIN

2015-2016

ALL SPORTS AND ACTIVITIES STUDENT ACCIDENT INSURANCE

Full Excess, No Deductible

$25,000 Maximum Benefit per Accident

80% U&C

In-Patient

Room & Board:	80% of Usual & Customary
Hospital Miscellaneous:	80% of Usual & Customary
X-rays:	80% of Usual & Customary
Physiotherapy:	80% of Usual & Customary
Surgery:	80% of Usual & Customary
(No more than one procedure through the same incision will be paid)	
Physician's Visits:	80% of Usual & Customary
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)	

Outpatient

Surgery:	80% of Usual & Customary
(No more than one procedure through the same incision will be paid)	
Day Surgery Miscellaneous:	80% of Usual & Customary
(*Facility Charge*)	
Physician's Visits:	80% of Usual & Customary
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)	
Physiotherapy:	80% of Usual & Customary
Emergency Room:	80% of Usual & Customary
(Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)	
X-rays, Diagnostic Testing:	80% of Usual & Customary
Lab:	80% of Usual & Customary

Other

Ambulance:	80% of Usual & Customary
Orthopedic Braces & Appliances:	80% of Usual & Customary
Dental:	80% of Usual & Customary
Neurological Consultant:	80% of Usual & Customary
Anesthetist:	35% of Usual & Customary
Assistant Surgeon:	35% of Usual & Customary
MRI/Cat Scan:	80% of Usual & Customary
Eyeglasses, Contact Lens and Hearing Aids:	80% of Usual & Customary
Prescriptions:	80% of Usual & Customary
Home Health Care:	10 visits / $50 per visit
Injections:	$15 per visit up to $75 maximum
MVA:	$5,000 maximum

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

PLAN AV

STUDENT ACCIDENT INSURANCE
2015/2016 VOLUNTARY COVERAGE

Description of Plan Benefits	Standard Plan	Elite Plan
Death	$10,000	$50,000
Dismemberment	$10,000	$100,000
Paralysis	N/A	$100,000
AME		
Benefit Maximum	$25,000	$5,000
Deductible (per accident)	$0	$100
Inpatient		
Hospital Miscellaneous/Room & Board:	100% up to $2,500	100% up to Benefit Maximum
Physician's Visit	$50 per visit	100% up to Benefit Maximum
Outpatient		
Day Surgery Misc: (*facility charge*)	100% up to $2,000	100% up to Benefit Maximum
X-Rays, Diagnostic Testing:	100% up to $300	100% up to Benefit Maximum
Physician's Visits:	$50 per visit	100% up to Benefit Maximum
Physical Therapy:	$50/visit to $500	100% up to Benefit Maximum
Hospital Emergency Room:	100% up to $300	100% up to Benefit Maximum
Emergency Room Physician:	$75 per visit	100% up to Benefit Maximum
MRI/Cat Scan:	100% up to $800	100% up to Benefit Maximum
Lab:	100% up to $150	100% up to Benefit Maximum
Home Health Care:	$50/visit to $500	100% up to Benefit Maximum
Inpatient and/or Outpatient		
Surgeon's Fees:	100% up to $2,000 (limited to the primary procedure per surgery)	100% up to Benefit Maximum
Anaesthetist:	25% of surgeon benefit	100% up to Benefit Maximum
Assistant Surgeon:	25% of surgeon benefit	100% up to Benefit Maximum
Ambulance:	100% up to $600	100% up to Benefit Maximum
Orthopaedic Braces & Appliances:	100% up to $500	100% up to Benefit Maximum
Eyeglasses, Contact Lens, Hearing Aids:	100% up to $400	100% up to Benefit Maximum
Dental:	100% up to $5,000	100% up to Benefit Maximum
Prescriptions	100% up to $100	100% up to Benefit Maximum
Injections:	100% up to $100	100% up to Benefit Maximum
MVA:	100% up to $5,000	100% up to Benefit Maximum
Felonious Assault and Violent Crime Benefit	N/A	10% of Principal Sum (death, dismemberment, paralysis)
Heart or Circulatory Malfunction Benefit	N/A	$5,000 (death, dismemberment, paralysis)
Rates		
School Time Coverage		
Grades K-6	$20.00 per year	$30.00 per year
Grades 7-12	$30.00 per year	$50.00 per year
24 Hour Coverage (includes Athletics, excluding High School Football)		
Grades K-6	$35.00 per year	$45.00 per year
Grades 7-12	$90.00 per year	$100.00 per year
Varsity Football Coverage		
(Grades 10-12 and Grades 7-9 if they practice or play with Grades 10-12)	$275	N/A

CATLIN

STUDENT INSURANCE PLANS

PLAN B

Texas Student Resources
Student Athletic/Activities Insurance
Health Special Risk

Kent Holbert
P.O. Box 581
Commerce, Texas 75429
Phone: 903 886-6943
Fax: 903 886-6947
E-mail: kholbert@koyote.com

2015-16 Student Insurance **Proposal for Mineola ISD**

Liberty Insurance Underwriters, Inc.

BLANKET AHLETICS & ACTIVITIES COVERAGE

Coverage Option	Grades	Plan Option	Premium
All UIL Athletics & Activities	7-12	TX Custom U&C*	$45,921.00

Includes At School, classroom, all school sponsored supervised activities including All UIL Athletics/Activities, cheerleading, band drill team, vocational classes, ROTC, FFA and 4-H (Includes Cheerleading Summer Camps).
***Includes Day Field Trips PK-12 (up to $25,000 medical).**

***Premier, Premier Plus and Custom U&C Plans – Optional** use of Texas Student Resources and Health Special Risk (HSR) Networks. -Providers have agreed to accept plan benefits as payment in full with no balance billing to parents.

***Plan Enhancements:** Post Injury **Concussion** Management Testing
Ambulance **Ground or Air** 100% U&C (first trip).
Wellness Benefit/Consultation

Claims administered and paid locally in Texas (Health Special Risk 866 409-5734).
Voluntary Accident Plan available to Students / Parents.
Visit our Website: www.K12StudentInsurance.com

CATASTROPHIC COVERAGE (Underwritten by Liberty Insurance Underwriters, Inc.)
Catastrophic Coverage includes medical benefits up to **$7,500,000.**

Coverage Option	Grades	Deductible	Medical Benefit	Premium
Class 3 *	7-12	$25,000	$7,500,000	$1,608.00
Optional $500,000 Catastrophic Cash Benefit				$ 977.00

Includes $10,000 AD&D and Loss of Life due to Heart or Circulatory Malfunction
* Class 3 includes all interscholastic athletes, cheerleaders, band members, majorettes, intramural sports participants, student trainers and student participants of school sponsored non-sport extracurricular activities.

Underwritten by:
Liberty Insurance Underwriters, Inc.
55 Water Street, 18th Floor
New York, NY 10041

Claims Administration:
Health Special Risk
P.O. Box 117588
Carrollton, TX 75011

Marketing:
Texas Student Resources
P.O. Box 581
Commerce, TX 75429

PLAN B

Liberty Mutual.
ACCIDENT & HEALTH

2015-2016
TEXAS MANDATORY PLANS
SCHEDULE OF BENEFITS

ACCIDENT MEDICAL EXPENSE BENEFIT	TX ECONOMY	TX U&C
Full Excess Accident Expense Benefit Maximum	$25,000	$25,000
First Covered Expenses must be received within	60 days after the Covered Injury	60 days after the Covered Injury
Benefit Period	1 year from the date of the Covered Injury	1 year from the date of the Covered Injury
Benefit Limit for Covered Injuries from any one motor vehicle Accident	$5,000	$5,000
INPATIENT HOSPITAL SERVICES		
Room and Board Expenses		
Semi-Private Room	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Intensive Care Unit/Critical Care Unit	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Hospital Miscellaneous Expenses	up to $250 per day, $4,000 per Covered Injury	100% of the Usual and Customary Charges
Emergency Room Treatment	up to $75 per Covered Injury	up to $500 per Covered Injury
Emergency Room Treatment must occur within	72 hours of the Covered Injury	72 hours of the Covered Injury
Registered Nursing Services	up to $400 per Covered Injury	100% of the Usual and Customary Charges
Physician Services		
Surgery	75% of the Usual and Customary Charges up to $3,500 per Covered Injury	100% of the Usual and Customary Charges up to $5,000 per Covered Injury
Assistant Surgeon	25% of Physician's Surgery Allowance	25% of Physician's Surgery Allowance
Anesthesia and its Administration	25% of Physician's Surgery Allowance	25% of Physician's Surgery Allowance
Physician In-Hospital Non –Surgical Visits	up to $20 per visit	100% of the Usual and Customary Charges
OUTPATIENT BENEFITS		
Physician Office Non- Surgical Visits	up to $20 per visit	100% of the Usual and Customary Charges up to 5 visits
Combined Maximum for CT scan, MRI	up to $250 per Covered Injury	up to $1,200 per Covered Injury
Reading amount	Included in CT scan, MRI	included in CT scan/MRI amount
X-ray	up to $100 per Covered Injury	up to $300 per Covered Injury
X-ray reading	Included in X-ray	included in X-ray amount
Laboratory tests	up to $25 per Covered Injury	up to $50 per Covered Injury
Outpatient Physiotherapy Benefit	up to 2 treatments; up to $40 per Covered Injury; 1 visit in a day	up to 20 treatments; up to $1,000 per Covered Injury; 1 visit in a day
Outpatient Orthopedic Appliances	up to $300 per Covered Injury	up to $600 per Covered Injury
Hospital Outpatient Surgery Facilities Payment	up to $750 per Covered Injury	up to $3,500 per Covered Injury
Ambulance Services	up to $100 per Policy Year	100% of the Usual and Customary Charges
Medical Equipment	up to $150 per Covered Injury	up to $150 per Covered Injury
Dental Services	up to $150 per Tooth	100% of the Usual and Customary Charges
Outpatient Prescription Drugs	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Post Injury Concussion Testing	No benefit	up to $75 per Covered Injury
Heart & Circulatory *Covered Condition:* Heat Exhaustion	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
AD&D BENEFITS		
Accidental Death	$10,000	$10,000
Accidental Dismemberment	$10,000	$10,000

TX Voluntary Schedule of Benefits

PLAN BV

ACCIDENT MEDICAL EXPENSE BENEFIT	ECONOMY	PREMIER
Full Excess Accident Expense Benefit Maximum	$25,000	$25,000
First Covered Expenses must be received within	60 days after the Covered Injury	60 days after the Covered Injury
Benefit Period	1 year from the date of the Covered Injury	1 year from the date of the Covered Injury
Benefit Limit for Covered Injuries from any one motor vehicle Accident	$5,000	$5,000
INPATIENT HOSPITAL SERVICES		
Room and Board Expenses		
Semi-Private Room	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Hospital Miscellaneous Expenses	up to $250 per day, to a maximum of $4,000 per Covered Injury	up to $250 per day to a maximum of $5,000 per Covered Injury
Emergency Room Treatment	up to $75 per Covered Injury	up to $150 per Covered Injury
Emergency Room Treatment must occur within	72 hours of the Covered Injury	72 hours of the Covered Injury
Registered Nursing Services	up to $400 per Covered Injury	up to $400 per Covered Injury
PHYSICIAN SERVICES		
Surgery	75% of the Usual and Customary Charges up to $3,500 per Covered Injury	75% of the Usual and Customary Charges up to $3,750 per Covered Injury
Assistant Surgeon	25% of Physician's Surgery Allowance	25% of Physician's Surgery Allowance
Anesthesia and its Administration	25% of Physician's Surgery Allowance	25% of Physician's Surgery Allowance
Physician In-Hospital Non-Surgical Visits	up to $20 per visit	up to $40 per visit
OUTPATIENT BENEFITS		
Physician Office Non-Surgical Visits	up to $20 per visit	up to $40 per visit
Combined Maximum for CT scan, MRI	up to $250 per Covered Injury	up to $500 per Covered Injury
X-ray	up to $100 per Covered Injury	up to $200 per Covered Injury
Laboratory tests	up to $50 per Covered Injury	up to $100 per Covered Injury
Outpatient Physiotherapy Benefit	up to 2 treatments; up to $40 per Covered Injury; 1 visit in a day	up to 5 treatments; up to $100 per Covered Injury; 1 visit in a day
Outpatient Orthopedic Appliances	up to $300 per Covered Injury	up to $300 per Covered Injury
Hospital Outpatient Surgery Facilities Payment	up to $750 per Covered Injury	up to $1,250 per Covered Injury
Ambulance Services	up to $100 per Policy Year	100% of the Usual and Customary Charges
Medical Equipment	up to $150 per Covered Injury	up to $150 per Covered Injury
Dental Services	up to $150 per Tooth	up to $250 per tooth
Outpatient Prescription Drugs	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
AVAILABLE ONLY WHEN SELECTED		
Deferred Treatment-Dental	up to $10,000 per Covered Injury; Cost of bridges, dentures, or replacement of dental repairs up to $250 per Covered Injury; 52 week benefit period	up to $10,000 per Covered Injury; Cost of bridges, dentures, or replacement of dental repairs up to $250 per Covered Injury; 52 week benefit period

TX Voluntary Rates

PLAN BV

	WITHOUT EXTENDED DENTAL		WITH EXTENDED DENTAL	
	Economy	Premier	Economy	Premier
Option A 24 Hour without HS Football	$ 128.00	$ 196.00	$ 137.00	$ 205.00
Option B At School without HS Football	$ 64.00	$ 94.00	$ 73.00	$ 103.00
Option C High School Football	$ 189.00	$ 291.00	$ 198.00	$ 300.00
Option C Spring High School Football	$ 76.00	$ 116.00	$ 85.00	$ 125.00

HSR
Health Special Risk, Inc.

Liberty Mutual
ACCIDENT & HEALTH

PLAN C-D

Texas Student Resources Student Insurance

Student Athletic / Activities Insurance

The Brokerage Store / Diversified Insurance Services

2015-16 Student Insurance Proposal for **Mineola ISD**

BLANKET ATHLETIC & ACTIVITIES COVERAGE

Coverage Option	Grades	Plan Option	Premium
Athletics & Activities	7-12	Texas Star Plan*	$34,350.00
		Texas Value Plan*	$49,050.00

Maximum Medical Benefit of $25,000 per injury.
Please see attached Schedule of Benefits for Texas Star Plan and Texas Value Plan

*Note: Students will have access to The Brokerage Store, Inc. Network that includes both USA MCO and the *Lone Star Athletic Injury Network*. Providers have agreed to accept negotiated PPO rates as Payment in Full and Full Assignment for covered services. PPO network applies to Value and Star Plan. Does not include Budget Plan Includes Trip Coverage PK-12 up to $2,000 per injury (day field trips).

Underwritten by: Columbian Life Insurance Company. Best Rating of A- (Excellent).

Claims filing Procedures: 1) Online Claim Submission
Or
2) Paper Claim Submission
Claim forms will be supplied and can also be downloaded from: www.sas-mn.com.

Voluntary Accident Plan available to Students.

CATASTROPHIC COVERAGE (Underwritten by Zurich American Insurance Co.)
Catastrophic Coverage includes medical benefits up to $7,500,000.

Coverage Option	Grades	Deductible	Medical Benefit	Premium
All UIL*	7-12	$25,000	$7,500,000	$1,560.00
Optional Cat Cash Benefit - $500,000				$ 708.00

*Includes all enrolled students of the School District, while participating in gym classes and extracurricular school activities including intramural and interscholastic sports, including band members, cheerleaders, majorettes, student coaches, student trainers and student managers. Also covered are ROTC, FFA, Vocational and some academic activities. Supervised travel to and from such games, activities and practice sessions are covered.

*Includes: Accidental Death & Dismemberment Benefit (AD&D)
$10,000 Death / $20,000 Dismemberment

PLAN C-D

MEDICAL BENEFITS

When injury covered by this policy results in treatment by a Licensed Physician within 180 days from the date of injury, the Company will pay the Usual and Customary expenses incurred for necessary Services and Supplies as listed below, for expenses actually incurred within one year from the date of injury up to a **Maximum Medical Benefit of $25,000 per injury**. This policy will pay benefits only after all Other Valid and Collectible Coverage has been paid.

All Amounts Listed Below are Per Injury

	TEXAS VALUE		TEXAS STAR
A. INPATIENT BENEFITS			
1. Hospital Room and Board	Semi-private Room Charges	.....	Semi-private Room Charges
2. Intensive Care (in lieu of Hospital Room and Board)	1.5 X Semi-private Room Charges	.....	1.5 X Semi-private Room Charges
3. Hospital Miscellaneous Services (all charges except Room & Board)	First day up to $1,000, thereafter up to $500 per day; max $5,000	.....	First day up to $500, thereafter up to $250 per day; max $2,500
4. Physician's Non-Surgical Visits (other than physical therapy; not paid day of surgery)	First day of treatment up to $50, subsequent visits up to $40, maximum 10 visits	.....	First day of treatment up to $40, subsequent visits up to $30, maximum 10 visits
5. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith)	Included in Hospital Misc. Benefit	.....	Included in Hospital Misc. Benefit
6. X-ray and Radiology Services	Included in Hospital Misc. Benefit	.....	Included in Hospital Misc. Benefit
7. Registered Nurse	U&C charges	.....	U&C charges
B. OUTPATIENT SURGERY BENEFITS			
1. Day Surgery (facility charge) Room supplies and all other expenses for outpatient surgery	U&C, up to $2,000	.....	U&C, up to $1,500
C. OTHER OUTPATIENT BENEFITS			
1. Hospital Emergency Room Charges	U&C, up to $300	.....	U&C, up to $200
2. X-ray and Radiology Services	U&C, $250 facility; $50 reading	.....	U&C, $175 facility; $25 reading
3. CAT Scans, MRI and Bone Scans	U&C, $750 facility; $50 reading	.....	U&C, $575 facility; $25 reading
4. Laboratory Services	U&C, up to $100	.....	U&C, up to $50
5. Physician's Non-Surgical Visits (not paid day of surgery)	$50 per visit, maximum 10 visits	.....	$40 per visit, maximum10 visits
6. Physician's Non-Surgical Visits (treatment for concussion)	$80 per visit, first 2 visits; then paid $50 per visit, up to 10 additional visits	.....	$60 per visit, first 2 visits; then paid $40 per visit, up to 10 additional visits
7. Emergency Room Physician's Non-Surgical Care (other than concussion)	U&C up to $150	.....	U&C up to $120
8. Orthopedic Appliances (when prescribed by a physician for healing)	U&C up to $500	.....	U&C, up to $500
9. Shots and Injections (within 24 hours of an injury)	U&C, up to $50	.....	U&C, up to $25
10. Prescription Drugs	U&C, up to $50	.....	U&C, up to $25
11. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith)	$50 per visit, maximum 5 visits	.....	$30 per visit, maximum 5 visits
12. Ambulance Service (air or ground)	U&C, up to $1,000	.....	U&C, up to $500
13. Eyeglass Replacement (if medical treatment is received for a covered injury)	U&C, up to $200	.....	U&C, up to $100
14. Durable Medical Equipment (post-surgical only)	U&C, up to $100	.....	U&C, up to $100
D. OTHER PHYSICIAN SERVICES			
1. Dental Treatment (in lieu of all other medical benefits, including x-rays of sound and natural teeth)	U&C, up to $1,000	.....	U&C, up to $500
2. Physician's Surgical Care (inpatient or outpatient) Only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession.	U&C up to $3,000	.....	U&C, up to $1,500
3. Assistant Surgeon Charges (inpatient or outpatient)	25% of Surgery Allowance	.....	25% of Surgery Allowance
4. Anesthetist Charges (inpatient or outpatient)	25% of Surgery Allowance	.....	25% of Surgery Allowance
E. MOTOR VEHICLE INJURY	U&C, up to $1,000, as scheduled above	.....	U&C, up to $1,000, as scheduled above

F. OTHER BENEFITS - Heat Stroke and Heat Exhaustion will be covered as any other accident.

G. FIELD TRIP COVERAGE - All students will be covered for one day field trips, with no overnight stay. Basic benefits apply for up to $2,000 per injury.

H. ACCIDENTAL DEATH AND DISMEMBERMENT - When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable.

Loss of Life	$ 2,000	Double Dismemberment	$10,000
Loss of an Eye	$ 2,000	Single Dismemberment	$ 2,000

For specific costs and further details of the coverage, including exclusions, reductions or limitations, and the terms under which the policy may be continued in force, see your agent or write the Company. The amount of benefits provided depends upon the plan selected and the premium will vary with the amount of benefits.

PLAN C-D V

MEDICAL BENEFITS

When injury covered by this policy results in treatment by a Licensed Physician within 180 days from the date of injury, the Company will pay the Usual and Customary (U&C) expenses incurred for necessary Services and Supplies as listed below, for expenses actually incurred within one year from the date of injury up to a Maximum Medical Benefit of $25,000 per injury. This policy will pay benefits regardless of Other Valid Coverage.

All Amounts Listed Below Are Per Injury

A. INPATIENT BENEFITS

1. Hospital Room and Board - Semi-private room charges
2. Intensive Care (in lieu of hospital room and board) - 1.5 X semi-private room charges
3. Hospital Miscellaneous Services (all charges except room & board) - U&C, first day up to $1,000, thereafter up to $500 per day; max $5,000
4. Physician's Non-Surgical Visits (does not include physical therapy; not paid day of surgery) - U&C, first day of treatment up to $50, subsequent visits up to $40; maximum 10 visits
5. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits) - Included in Hospital Miscellaneous Services
6. X-ray and Radiology Services - Included in Hospital Miscellaneous Services
7. Registered Nurse - U&C

B. OUTPATIENT SURGERY BENEFITS

1. Day Surgery (facility charge; room supplies and all other expenses for out-patient surgery - U&C, up to $2,000

C. OTHER OUTPATIENT BENEFITS

1. Hospital Emergency Room Charges - U&C, up to $300
2. X-ray and Radiology Services - U&C up to: $250 Facility; $50 Reading
3. CAT Scans, MRI and Bone Scans - U&C up to: $750 Facility; $50 Reading
4. Laboratory Services - U&C, up to $100
5. Physician's Non-Surgical Visits (not paid day of surgery) - U&C, up to $50 per visit, 10 visit maximum
6. Emergency Room Physician's Non-Surgical Care - U&C, up to $150
7. Orthopedic Appliances (when prescribed by a physician for healing) - U&C, up to $500
8. Shots and Injections (within 24 hours of an injury) - U&C, up to $50
9. Prescription Drugs - U&C, up to $50

C. OTHER OUTPATIENT BENEFITS (cont.)

10. Physical Therapy Treatment (includes whirlpool, diathermy, EMS massage, manipulation or adjustments in any form, and/or office visits - U&C, up to $50 per visit, maximum 5 visits
11. Ambulance Service (air or ground) - U&C, up to $1,000
12. Eyeglass Replacement (if medical treatment is also received for a covered injury) - U&C, up to $200
13. Durable Medical Equipment (post-surgical only) - U&C, up to $100

D. OTHER PHYSICIAN SERVICES

1. Dental Treatment (in lieu of all other medical benefits, including x-rays o sound and natural teeth) - U&C, up to $200 per tooth
2. Physician's Surgical Care (inpatient or outpatient) Only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession - U&C up to $2,500
3. Assistant Surgeon Charges (inpatient or outpatient) - 25% of Surgery Allowance
4. Anesthetist Charges (inpatient or outpatient) - 25% of Surgery Allowance

E. MOTOR VEHICLE INJURY - Same as any Injury, up to $1,000

F. OTHER BENEFITS - Heat Stroke and Heat Exhaustion will be covered as any other accident.

G. ACCIDENTAL DEATH AND DISMEMBERMENT - When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable:

Loss of Life	$ 2,000
Double Dismemberment	$10,000
Loss of an Eye	$ 2,000
Single Dismemberment	$ 2,000

The policy contains a provision limiting coverage to usual and customary charges. This limitation may result in additional out-of-pocket expenses for the insured.

EXCLUSIONS

This Policy does not provide benefits for expenses resulting from:

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics.
2. Injuries for which benefits are payable under Worker' Compensation or Employer's Liability Laws.
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Replacement of contact lenses, hearing aids or prescriptions or examinations thereof.
5. The participation, practice or play of UIL activities including travel to or from such activity, practice, or play for students in the 7th grade or above, unless such premium is paid.

IT IS NOT THE INTENT OF THE POLICY TO PROVIDE BENEFITS FOR AN EXISTING MEDICAL PROBLEM. A re-injury will not be covered if the insured has received treatment within a period of 180 days prior to the Effective Date of the policy.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Accident Insurance Policy Form GH-2200 (and any state specific), and any applicable endorsement(s) Extended Dental Coverage GHE-2201 (and any state specific). This policy is considered term accident insurance and is non-renewable. This product may not be available in all states and is subject to individual state regulations. The Master Policy is issued to the School District/School. A copy of the Privacy Notice may be obtained on the website www.sas-mn.com.

PLAN CDV

The Voluntary Coverage Plan

This plan allows the school to offer student accident insurance coverage to parents on an optional basis. Each student in the District is required to take the information home to their parents. This plan will give the School Board and Administration a method to inform parents that the District is not responsible to pay for medical expense caused by a school injury.

Common Questions Answered

1. The Full-Time and School-Time Coverage does not cover participation in UIL activities for students in the 7th grade or above.
2. UIL activities coverage must be purchased with either Full-Time Coverage or School-Time Coverage. It covers all UIL activities injuries except football for students in the 10-12th grades and grades 7-9 football if students practice or play with grades 10-12. The cost for 10-12th grade football is an additional $325.00. Football for students in grades 7-9 is included in the School-Time or Full-Time Coverage with UIL Activities Coverage, unless the student is practicing or playing with grades 10-12.
3. Extended Dental Coverage may be purchased separately and provides coverage during all UIL activities.

How To Enroll In The Program

1. IF YOU HAVE IMMEDIATE QUESTIONS PLEASE CALL (210) 366-4800 or (800) 366-4810.
2. Complete the enclosed application and mail to:

THE BROKERAGE STORE
4114 Pond Hill Road • Suite 100
San Antonio, TX 78231

3. Only one student accident plan will be offered by the district.
4. A billing for Group premium will not be made until July.
5. A supply of claim forms, solicitation envelopes and other materials will be sent to the school in July.

Internet Access

Available at www.sas-mn.com. You will be given an administrator access code. You will have immediate access to your:

- Master Policy
- Roster
- Claim Status
- Claim Forms

PREMIUMS

	NO UIL Activities Coverage	With UIL Activities Coverage
School-Time Coverage (PK - 12)	$ 25.00	$ 115.00
Full-Time Coverage (PK - 12)	$ 105.00	$ 195.00
Football (Grades 10 - 12 and grades 7-9 football, if they practice or play with grades 10-12)	$ 325.00	
Extended Dental (PK - 12)	$ 9.00	

UIL Activiites Coverage: includes all school sports and activities that are school sponsored and supervised except Football (Grades 10 - 12 and grades 7-9 football, if students practice or play with grades 10-12).

PLAN E-F

Texas Student Resources, Inc.
Student Athletic/Activities Insurance
Mutual of Omaha / Health Special Risk

Kent Holbert
P.O. Box 581
Commerce, Texas 75429
Phone: 903 886-6943
Fax: 903 886-6947
E-mail: kholbert@koyote.com

2015-16 Student Insurance **Proposal for Mineola ISD**
Mutual of Omaha

BLANKET ATHLETIC & ACTIVITIES COVERAGE

Coverage Option	Grades	Plan Option	Premium
All UIL Athletics & Activities*	7-12	Premier Plan*	$33,489.00
		Premier Plus*	$41,313.00

*Includes all UIL Athletics/Activities, cheerleading, band drill team, vocational classes, ROTC, FFA and 4-H (**Excludes** Cheerleading Summer Camps).
***Includes Day Field Trips PK-12.**

***Premier and Premier Plus Plans – Optional** use of Texas Student Resources and Health Special Risk (HSR) Networks. Providers have agreed to accept plan benefits as payment in full with no balance billing to parents.

***Plan Enhancements:** Post Injury **Concussion** Management Testing
Ambulance includes **Ground or Air** 100% U&C
Injection Benefit

Claims administered and paid locally in Texas (Health Special Risk – 866 409-5734)

Voluntary Accident Plan available to Students (Underwritten by Mutual of Omaha).

Visit our Website: www.K12StudentInsurance.com

CATASTROPHIC COVERAGE (Underwritten by Mutual of Omaha).
Catastrophic Coverage includes medical benefits up to **$7,500,000.**

Coverage Option	Grades	Deductible	Medical Benefit	Premium
Class 3 *	7-12	$25,000	$7,500,000	$1,559.00
Optional $500,000 Catastrophic Cash Benefit				$ 947.00

Includes $10,000 AD&D Benefit and loss of life due to Heart or Circulatory Malfunction.

* Class 3 includes all interscholastic athletes, cheerleaders, band members, majorettes, intramural sports participants, gym class participants, student coaches, student managers, student trainers and student participants of school sponsored non-sport extracurricular activities.

Underwritten by:
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

Claims Administration:
Health Special Risk
P.O. Box 117588
Carrollton, TX 75011

Marketing:
Texas Student Resources
P.O. Box 581
Commerce, TX 75429

PLAN E-F

HSR
Health Special Risk, Inc.

2015-2016 TEXAS K-12 INSURANCE SCHEDULES OF BENEFITS

Insurance coverage underwritten by Mutual of Omaha Insurance Company; Mutual of Omaha Plaza, Omaha, NE 68175

Coverage is provided for loss due to a covered injury up to a maximum per injury benefit amount of $25,000 ($5,000 for Motor Vehicle Injuries). Treatment of covered injuries must begin within 60 days of the accident date. Only eligible expenses incurred within 52 weeks from the date of the accident are covered. The maximum benefit amount per service/treatment is as shown below. Benefits will be paid only for such expense which is not recoverable from any other insurance policy, service contract or workers' compensation.

INPATIENT:	PREMIER PLUS MANDATORY PLAN		PREMIER MANDATORY PLAN	
Room & Board	Semi-Private Room Rate		Semi-Private Room Rate	
Intensive Care	1.5 times the Semi-Private Room Rate		1.5 times the Semi-Private Room Rate	
Hospital Miscellaneous	Up to $750 1st day, $250/ day thereafter to a maximum of $5,000		Up to $250/ day to a maximum of $5,000	
Private Duty Nursing (Registered Nurse)	100% of Allowable Expense		Up to $400/ injury	
Physician's Nonsurgical Visits	Up to $40/ visit		Up to $40/ visit	
	(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)			
Orthopedic Braces and Appliances	Included in Hospital Miscellaneous Benefit		Included in Hospital Miscellaneous Benefit	
OUTPATIENT:				
Hospital Outpatient Surgery – Facility Charge	Up to $2,000/ injury		Up to $1,500/ injury	
Physician's Nonsurgical Visits (Non-Emergency Room)	Up to $40/ visit		Up to $40/ visit	
	(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)			
Physiotherapy	Up to $25/ visit, up to $250/ injury (Benefits are limited to one visit per day)		Up to $25/ visit, up to 5 visits/ injury (Benefits are limited to one visit per day)	
Emergency Room	Up to $250/ injury		Up to $150/ injury	
	(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)			
Physician Emergency Room	Up to $100/ injury		Up to $60/ injury	
X-Ray	**Services:** Up to $200/ injury	**Reading:** Up to $50/ injury	**Services:** Up to $200/ injury	**Reading:** Up to $25/ injury
Diagnostic Imaging (Cat Scan, MRI)	**Services:** Up to $750/ injury	**Reading:** Up to $50/ injury	**Services:** Up to $500/ injury	**Reading:** Up to $25/ injury
Laboratory	Up to $50/ injury		Up to $50/ injury	
Injections	Up to $25/injury		Up to $25/injury	
Prescription Drugs	100% of Allowable Expense		100% of Allowable Expense	
Orthopedic Braces and Appliances	Up to $500/ injury (When prescribed by a physician for healing)		Up to $500/ injury (When prescribed by a physician for healing)	
Durable Medical Equipment (Post Surgical Only)	Up to $150/ injury		Up to $150/ injury	
INPATIENT AND/OR OUTPATIENT:				
Surgeon's Fees	90% of Allowable Expense up to a $4,500 maximum (Limited to the primary procedure per surgery)		75% of Allowable Expense up to a $3,750 maximum (Limited to the primary procedure per surgery)	
Anesthetist/Assistant Surgeon	25% of surgeon's allowance		25% of surgeon's allowance	
Ambulance	100% of Allowable Expense, first trip to the hospital		100% of Allowable Expense, first trip to the hospital	
Treatment of Heat Exhaustion	100% of Allowable Expenses		100% of Allowable Expenses	
Dental	100% of Allowable Expense (Benefits are paid on sound natural teeth only)		Up to $250/ tooth (Benefits are paid on sound natural teeth only)	
Eyeglasses, Contact Lenses & Hearing Aids	100% of Allowable Expense for replacement if broken due to injury		100% of Allowable Expense for replacement if broken due to injury	
Post Injury Concussion Management Testing	Up to $75/ injury		Up to $50/ injury	

PLAN E-FV

HSR
Health Special Risk, Inc.

2015-2016
TEXAS
K-12 VOLUNTARY PLANS
SCHEDULE OF BENEFITS

Coverage underwritten by Mutual of Omaha Insurance Company; Mutual of Omaha Plaza, Omaha, NE 68175

Coverage is provided for loss due to a covered injury up to a maximum per injury benefit amount of $25,000 ($5,000 for Motor Vehicle Injuries). Treatment of covered injuries must begin within 60 days of the accident date. Only eligible expenses incurred within 52 weeks from the date of the accident are covered. The maximum benefit amount per service/treatment is as shown below. Benefits will be paid only for such expense which is not recoverable from any other insurance policy, service contract or workers' compensation.

INPATIENT:	**PREMIER VOLUNTARY PLAN**	**ECONOMY VOLUNTARY PLAN**
Room & Board	Semi-Private Room Rate	Semi-Private Room Rate
Intensive Care	1.5 times the Semi-Private Room Rate	1.5 times the Semi-Private Room Rate
Hospital Miscellaneous	Up to $250 per day, to a maximum of $5,000	Up to $250 per day, to a maximum of $4,000
Registered Nurse	Up to $400 per injury	Up to $400 per injury
Physician's Nonsurgical Visits	Up to $40 per visit	Up to $20 per visit
(Benefits are limited to one visit per day and do not apply when related to surgery)		
Orthopedic Braces and Appliances	Included in Hospital Miscellaneous Benefit	Included in Hospital Miscellaneous Benefit
OUTPATIENT:		
Hospital Outpatient Surgery – Facility Charge	Up to $1,250 per injury	Up to $750 per injury
Physician's Nonsurgical Visits	Up to $40 per visit	Up to $20 per visit
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)		
Physiotherapy	Up to $20 per visit, to a $100 maximum (Benefits are limited to one visit per day)	Up to $20 per visit, to a $40 maximum (Benefits are limited to one visit per day)
Emergency Room	Up to $150 per injury	Up to $75 per injury
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)		
Physician Emergency Room	Up to $60/injury	Up to $40/injury
X-Ray Services (includes charges for reading)	Up to $200 per injury	Up to $100 per injury
Cat Scan/MRI Services (includes charges for reading)	Up to $500 per injury	Up to $250 per injury
Laboratory	Up to $50 per injury	Up to $25 per injury
Injections	Up to $25 per injury	Up to $25 per injury
Prescription Drugs	100% of Allowable Expense	100% of Allowable Expense
Orthopedic Braces and Appliances	Up to $300 per injury (When prescribed by a physician for healing)	Up to $300 per injury (When prescribed by a physician for healing)
Durable Medical Equipment (Post Surgical Only)	Up to $150 per injury	Up to $150 per injury
INPATIENT AND/OR OUTPATIENT:		
Surgeon's Fees	75% of Allowable Expense up to a $3,750 maximum (Limited to the primary procedure per surgery)	75% of Allowable Expense up to a $3,500 maximum (Limited to the primary procedure per surgery)
Anesthetist/Assistant Surgeon	25% of surgeon's allowance	25% of surgeon's allowance
Ambulance	100% of Allowable Expense, first trip to the hospital	First trip to the hospital up to a $100 maximum
Treatment of Heat Exhaustion	100% of Allowable Expense	100% of Allowable Expense
Dental	Up to $250 per tooth (Benefits are paid on sound natural teeth only)	Up to $150 per tooth (Benefits are paid on sound natural teeth only)
Replacement of Eyeglasses, Contact Lenses & Hearing Aids	100% of Allowable Expense for replacement if broken due to injury	100% of Allowable Expense for replacement if broken due to injury
Extended Dental Coverage	This is supplemental coverage for expenses resulting from covered accidental injuries. The dental benefits provided are: (a) 100% of Allowable Expense for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000 and (b) dental expenses toward the cost of bridges, dentures or replacement of previous dental repairs to a maximum of $250. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof.	

HSR
Health Special Risk, Inc.

PLAN E-FV

2015-2016
TEXAS
K-12 INSURANCE
VOLUNTARY RATE SCHEDULES

Coverage Underwritten by: Mutual of Omaha Insurance Company; Mutual of Omaha Plaza; Omaha, NE 68175

OPTION A: 24-HOUR COVERAGE

Provides coverage for injuries incurred 24-Hours a day, 365 days a year (except injuries incurred while participating in High School Football events/activities).

	PREMIER VOLUNTARY	ECONOMY VOLUNTARY
With Extended Dental	$205.00 Per Student	$138.00 Per Student
Without Extended Dental	$196.00 Per Student	$128.00 Per Student

OPTION B: AT SCHOOL COVERAGE

Provides coverage for injuries incurred at school, during school sponsored and supervised activities (except injuries incurred while participating in High School Football events/activities).

	PREMIER VOLUNTARY	ECONOMY VOLUNTARY
With Extended Dental	$103.00 Per Student	$73.00 Per Student
Without Extended Dental	$94.00 Per Student	$64.00 Per Student

OPTION C: FOOTBALL COVERAGE

Provides coverage for injuries incurred while participating in sponsored and supervised practice or play for High School Football events

Note: Any 9th grade student that plays with the High School Football Team (grades 10-12) must purchase Football coverage.

	PREMIER VOLUNTARY	ECONOMY VOLUNTARY
With Extended Dental	$300.00 Per Student	$198.00 Per Student
Without Extended Dental	$291.00 Per Student	$189.00 Per Student
Spring Football With Extended Dental	$125.00 Per Student	$85.00 Per Student
Spring Football Without Extended Dental	$116.00 Per Student	$76.00 Per Student

Extended Dental Coverage must be purchased in conjunction with a 24-Hour, At School or Football program, it cannot be purchased as a stand alone coverage.