2014/2015 STUDENT ATHLETIC/ACCIDENT INSURANCE

	80% U&C-Plan-Current Catlin Catlin	90% Limits Catlin Catlin	Premier Plan Liberty Mutual Liberty Mutual	Premier Plus Liberty Mutual Liberty Mutual	80% U&C Liberty Mutual Liberty Mutual
PREMIUM	47,500	40,675	33,583	42,177	43,819
CATASTROPHIC	2,062	2,062	2,584	2,584	2,584
TOTAL	$49,562	$42,737	$36,167	$44,761	$46,403
max benefit	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
cash benefit	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

voluntary plan	Plan A	Plan B	Economy	Premier
at school	29	22	64	94
24 hour plan	99	68	128	196
extended dental	8/8	8/8	9/9	9/9
Football only	n/a	n/a	189/198	291/300
Spring Football	n/a	n/a	76/85	116/125

Claims Paid

	2008-2009	$23,424
	2009-2010	$22,445
	2010-2011	$26,713
	2011-2012	$40,525
	2012-2013	$30,701
Projected	2013-2014	$25,991

80% U&C	80% U&C
SMIC	STARR Co
SMIC	STARR Co
72,500	73,500
3,032	N/A
$75,532	
5,000,000	
10 years	
0	

Watkins Insurance
GROUP

Mineola ISD Quotation for Student Accident Plan

Premium: $47,500	Current Plan: 80% U&C, no balance bill: Catlin Insurance
Premium: $72,500	Quote: 80% U&C: Special Markets Insurance Consultants
Premium: $73,500	Quote: 80% U&C: Starr Companies

Catastrophic Coverage Renewal

Catlin Insurance Company, Inc.

Class II - Per Campus

All Sports including band, cheerleaders, drill team, student coaches, student trainers, student managers intramural sports, gym classes, non-sport extracurricular

Maximum Benefit per Accident	$7,500,000
Deductible	25,000
Deductible Establisment period	2 years
Benefit Period, per accident	10 years
Total including AD&D	$1,418
Total including $500,000 cash benefit and AD&D	$2,062

CATLIN

2014-2015

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.

40,675-00

MINEOLA ISD ~ SCHEDULE OF BENEFITS
ACCIDENT ONLY
MAXIMUM BENEFIT $25,000 For Each Injury
52 Week Benefit Period, Full Excess

In-Patient	
Room & Board:	90% Usual &Customary up to $500/day
Hospital Miscellaneous:	90% Usual &Customary up to $3,500 Maximum
X-Rays:	$500 Maximum
Physical Therapy:	$35 per visit / $350 Maximum
Surgery: *(No more than one procedure through the same incision will be paid)*	90% Usual &Customary up to $2,500 Maximum
Physician's Visits: *(Benefits limited to one visit per day and do not apply when related to surgery or Physical Therapy)*	$45 per visit
Outpatient	
Surgery: *(No more than one procedure through the same incision will be paid)*	90 % Usual &Customary up to $2,500 Maximum
Day Surgery Miscellaneous: *(Facility Charge)*	$1,250 Maximum
Physician's Visits: *(Benefits limited to one visit per day and do not apply when related to surgery or Physical Therapy)*	$45 per visit
Physical Therapy:	$35 per visit / $350 Maximum
Emergency Room: (Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)	$500 Maximum
X-rays, Diagnostic Testing:	$500 Maximum
Lab:	100% Usual &Customary
Other	
Ambulance:	$700 Maximum
Orthopedic Braces and Appliances:	$500 Maximum
Dental:	$500 per tooth
Anesthetist:	$500 Maximum
Assistant Surgeon:	$500 Maximum
MRI/Cat Scan:	90 % Usual &Customary up to $1,000 Maximum
Eyeglasses, Contact Lens and Hearing Aids:	$500 Maximum
Prescriptions:	$200 Maximum
Home Health Care:	10 Visits / $50 per visit
Injections:	$15 per visit /$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.

EXCLUSIONS AND LIMITATIONS

The Policy does not cover any loss as a result of:
1. Suicide or attempted suicide; Intentionally self-inflicted Injury.
2. War or any act of war, whether declared or not; active duty service in the: military; naval; or air force of any country or international organization; active participation in a riot, or insurrection.
3. Sickness; disease; bodily or mental infirmity; bacterial or viral infection; or medical or viral infection; or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound.
4. Commission of, or attempt to commit: a felony; an assault; or other illegal activity; being under the influence of drugs or intoxicants, unless taken under the advice of a Doctor.
5. Flight in; boarding; or alighting from an aircraft or any craft designed to fly above the Earth's surface, except as: a fare-paying passenger on a regularly scheduled commercial or charter airline, a passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight.
6. Travel in or on; entering into or alighting from; or being struck by any on-road or off-road motorized vehicle not requiring licensing as a motor vehicle; an Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; participation in any activity or hazard not specifically covered by the Policy.
7. A cardiovascular malfunction or stroke caused solely and exclusively by exertion, as verified by a Doctor, while the Covered Person participates in a Covered Activity; aggravation of an Injury the Covered Person suffered before participating in that Covered Activity, unless We receive a written medical release from the Covered Person's Doctor.
8. Treatment by any Immediate Family Member or member of the Covered Person's household.
9. Treatment of hernia; Osgood-Schlatter's Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; detached retina unless caused by an Injury; or mental disorder or psychological or psychiatric care or treatment; whether or not caused by a Covered Accident.
10. Pregnancy; childbirth; miscarriage; abortion; or any complications of childbirth; miscarriage; abortion.
11. Cosmetic surgery, except for reconstructive surgery needed as the result of an Injury; Any elective treatment, surgery, health treatment, or examination; treatment of Injuries that result over a period of time; routine care or physicals; rest cures or custodial care.
12. Sexually transmitted diseases or immune deficiency disorders and related conditions.
13. Covered medical expenses for which the Covered Person would not be responsible for in the absence of the Policy
14. Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy).

EXCLUSIONES Y LIMITACIONES

La Póliza no cubre ninguna pérdida como resultado de:
1. Suicidio o intento de suicidio: Lesiones autoinfligidas intencionalmente.
2. Guerra o cualquier acto de guerra, ya sea declarado o no; servicio activo en el: militar; naval; o la fuerza aérea de cualquier país u organización internacional; participación activa en una revuelta o insurrección.
3. Enfermedad; enfermedad; enfermedad corporal o mental; infección viral o bacteriana; o infección viral o médica; o tratamiento médico o quirúrgico, excepto cualquier infección bacteriana resultante de un accidente externo corte o herida.
4. Comisión de, o intente cometer: un delito; un asalto; u otra actividad ilegal; estar bajo la influencia de drogas o estupefacientes, a menos que tomen bajo el asesoramiento de un médico.
5. Vuelo en; embarque, o bajarse de un avión o cualquier nave diseñada para volar por encima de la superficie de la tierra, excepto como: un pasajero pagando tarifa comercial regularmente programada o aerolínea charter, un pasajero en un avión privado, no regulares utilizado con fines de placer con ningún propósito comercial durante el vuelo.
6. Viajar en o entrar o bajar del vehículo o ser golpeado por cualquier vehículo motorizado en carretera o todo terreno que no requieren licencias como un vehículo de motor; un accidente si la persona cubierto es el operador de un vehículo de motor y no posee la licencia de un operador válido del vehículo de motor; participación en cualquier actividad o peligro no cubierto por la póliza.
7. Un fallo cardiovascular o accidente cerebrovascular provocado únicamente y exclusivamente por el esfuerzo, según lo verificado por un médico, mientras que la persona cubierta participa en una actividad cubierto; agravación de una lesión que sufrió de la persona cubierta antes de participar en esa actividad cubierto, a menos que recibamos un comunicado escrito médico del médico de la persona cubierta.
8. Tratamiento por cualquier miembro de su familia inmediata o miembros del hogar de la persona cubierta.
9. Tratamiento de la hernia; Enfermedad de Osgood-Schlatter; Osteocondritis; apendicitis; osteomielitis; enfermedad cardíaca o condiciones; fracturas patológicas; debilidad congénita; unifamiliar retina salvo causado por una lesión; o trastorno mental o psicológico o psiquiátrico cuidado o tratamiento; o no causados por un accidente cubierto.
10. Embarazo; parto; aborto espontáneo; aborto; o complicaciones del parto: aborto espontáneo; aborto.
11. Cirugía, excepto cirugía reconstructiva necesaria como resultado de una lesión; Cualquier tratamiento electivo, cirugía, tratamiento de salud o examen; tratamiento de las lesiones que resultan en un período de tiempo; atención de rutina o exámenes físicos; curas de resto o cuidados de custodia.
12. Enfermedades de transmisión sexual o trastornos de inmunodeficiencia y condiciones relacionadas.
13. Cubiertos los gastos médicos para que la persona cubierta no sería responsable en ausencia de la política
14. Daño o pérdida de las dentaduras o puentes; o daños al equipo existente de ortodoncia (excepto como específicamente cubierto por la póliza).

Enrollment Application for Student Insurance administered by Student Insurance Plans
Solicitud de inscripción de seguro para estudiantes administrado por Student Insurance Plans

Coverage subject to eligibility confirmation and receipt of enrollment application and premium by Student Insurance Plans. Please see the master policy for actual effective date of coverage./Cobertura sujeta a confirmación de elegibilidad y recibo de la solicitud de inscripción y la prima en Student Insurance Plans. Sírvase leer la póliza maestra para obtener la fecha real de vigencia de la cobertura. **Please remit this form and premium payment to Student Insurance Plans P.O. Box 4000, Frisco, Texas 75034**/Sírvase remitir el presente formulario con el pago de la prima a Student Insurance Plans P.O. Box 4000, Frisco, Texas 75034

(Please Print) School District Name/(Escriba en letra de molde) Nombre del Distrito escolar: _____

Student's Last Name/Apellido del estudiante: _____ First Name/Nombre de pila: _____

Address/Dirección: _____ City/State/Zip/Ciudad/Estado/Código postal: _____

Student's ID #/Nº de identificación del estudiante: _____ Date of Birth/Fecha de nacimiento: _____

School Name/Nombre de la escuela: _____ HS _____ MS _____ Elem _____ Grade/Grado que cursa _____
(HS = bachillerato, MS = secundaria, Elem = primaria)

Parent/Guardian Name/Nombre del padre/madre/tutor: _____

ANNUAL PREMIUM/PRIMA ANUAL	**PLAN A**		**PLAN B**
(1) School Time Accident Coverage (Cobertura contra accidentes durante el horario escolar)	☐ $29.00		☐ $22.00
(2) 24 Hour Accident Coverage (Cobertura contra accidentes las 24 horas)	☐ $99.00		☐ $68.00
(3) Extended Accidental Dental Coverage (Extensión a cobertura dental contra accidentes)		☐ $8.00	

Online enrollment available via Visa or Mastercard at www.studentinsuranceplans.com
Inscripción en línea disponible mediante pago con Visa o Mastercard en www.studentinsuranceplans.com

Total Amt. Enclosed/Cant. total adjunta: $ _____ Make check payable to/Haga el cheque a nombre de: Student Insurance Plans

Note: Premium is considered fully earned upon receipt. Once coverage is in effect, no refunds will be given.
Nota: La prima se considera como ganada por completo en el momento de recibirla. Una vez que entre en vigor la cobertura, no se darán reembolsos.

Any person who knowingly and with the 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./Cualquier persona que, con conocimiento, y con la intención de defraudar a cualquier compañía de seguros u otra persona, presente una solicitud de seguro o declaración de reclamación que contenga información materialmente falsa u oculte, con el fin de engañar, información concerniente a cualquier dato material al respecto, comete un acto fraudulento de seguros, lo cual es un delito y somete a tal persona a la aplicación de sanciones penales y civiles.

Benefits subject to the terms and conditions of the insurance policy issued on behalf of Catlin Insurance Company, Inc., Houston, TX to the school; please contact the school for a copy of this policy.
Los beneficios están sujetos a los términos y condiciones de la póliza de seguros emitida en nombre de Catlin Insurance Company, Inc., Houston, TX a la escuela; favor de contactar a la escuela para obtener una copia de esta póliza.

DM-C-TX

STUDENT INSURANCE PLANS
PLANES DE SEGURO PARA ESTUDIANTES

This policy has no deductible. / Esta póliza no tiene deducible.

Independent Medical Systems

Student Accident Insurance Protection up to $25,000/Protección de seguro contra accidentes para estudiantes hasta de $25,000

STUDENT INSURANCE PLANS · PO BOX 4000 · FRISCO, TX 75034 · (469) 579-4139 · (844) 882-8318

The policy provides for loss due to a covered injury up to $25,000 for each injury. Treatment must begin within 90 days from the date of the injury. Benefits will be paid for the covered medical expenses incurred within 52 weeks from the date of injury. Please see the reverse side of this page for exclusions and enrollment form.
La póliza cubre las pérdidas debido a una lesión cubierta hasta por $25,000 por cada lesión. El tratamiento debe comenzar dentro de los 90 días contados a partir de la fecha de la lesión. Los beneficios serán pagados por los gastos médicos cubiertos, incurridos dentro de las 52 semanas contadas a partir de la fecha de la lesión. Consulte el dorso de esta página con las exclusiones y formulario de inscripción.

	PLAN A	PLAN B
Room & Board (Alojamiento y comidas):	90% U&C* up to $500/day 90% U y A* hasta $500/día	$150.00 per day $150.00 por día
Hospital Miscellaneous (Gastos misceláneos de hospital):	90% U&C to $3,500 maximum 90% U y A hasta $3,500 máximo	$1,500 maximum $1,500 máximo
Day Surgery Misc - Facility Charge (Día de cirugía, misceláneos - Cargo por instalaciones):	$1,250 maximum $1,250 máximo	$750 maximum $750 máximo
Surgery (Cirugía):	90% U&C to $2,500 maximum 90% U y A hasta $2,500 máximo	$1,500 maximum $1,500 máximo
X-Rays/Diagnostic Testing (Rayos X/Pruebas de diagnosis):	$500 maximum $500 máximo	$150 maximum $150 máximo
Physician's Visits (Visitas del médico):	$45 per visit $45 por visita	$25 per visit $25 por visita
Physical Therapy (Terapia física):	$35/visit to $350 maximum $35/visita hasta $350 máximo	$25/visit to $150 maximum $25/visita hasta $150 máximo
Emergency Room - within 72 hours (Sala de Emergencia - dentro de 72 horas):	$500 maximum $500 máximo	$100 maximum $100 máximo
Lab (Laboratorio):	100% U&C 100% U y A	80% U&C 80% U y A
Ambulance (Ambulancia):	$700 maximum $700 máximo	$350 maximum $350 máximo
Orthopedic Braces & Appliances (DME) (Aparatos y dispositivos ortopédicos):	$500 maximum $500 máximo	$200 maximum $200 máximo
Anesthetist (Anestesista):	$500 maximum $500 máximo	$300 maximum $300 máximo
Assistant Surgeon (Cirujano asistente):	$500 maximum $500 máximo	$300 maximum $300 máximo
MRI/Cat Scan (Resonancia magnética/Tomodensitometria):	90% U&C to $1,000 maximum 90% U y A hasta $1,000 máximo	$350 maximum $350 máximo
Eyeglasses, Contact Lens, Hearing Aids (Lentes, lentes de contacto, audioprótesis):	$500 maximum $500 máximo	$200 maximum $200 máximo
Dental (cuidado dental):	$500 per tooth $500 por pieza dental	$200 per tooth $200 por pieza dental
Prescriptions (Medicamentos recetados):	$200 maximum $200 máximo	$75 maximum $75 máximo
Home Health Care (Atención médica en casa):	10 visits/$50 per visit 10 visitas/$50 por visita	10 visits/$50 per visit 10 visitas/$50 por visita
Injections (Inyecciones):	$15/visit to $75 maximum $15/visita hasta $75 máximo	$15/visit to $75 maximum $15/visita hasta $75 máximo
Motor Vehicle Accident (Accidente automovilístico):	$5,000 maximum $5,000 máximo	$5,000 maximum $5,000 máximo

**U&C = Usual & Customary (U y A = Usual y Acostumbrado)*

Student Accident Insurance Options
Opciones de seguro contra accidentes para estudiantes

School Time: Coverage is in force for the hours and days when school is in session and while attending school sponsored and supervised activities on or off the school premises.
Durante el horario escolar: La cobertura está en vigor durante las horas y los días en los que la escuela está en sesión y mientras el estudiante asista a actividades patrocinadas y supervisadas por la escuela, dentro o fuera de las instalaciones de la escuela.

24 Hour: Coverage is in force around the clock, 24 hours a day, including summer, weekends and vacation periods. Protected at home or while away – any time, any place, anywhere. Coverage expires the day the school reopens the following Fall.
Durante las 24 horas: La cobertura está en vigor día y noche, las 24 horas del día, incluso durante el verano, los fines de semana y los periodos de vacaciones. El estudiante está protegido en casa o cuando está fuera, en todo momento y en todo lugar. La cobertura se vence el día que la escuela reanuda operaciones en el otoño.

Accidental Dental Treatment Benefit: By adding an additional premium to the base plan rates, dental benefits may be extended under the overall maximum benefit to provide payment of covered expenses to a maximum of $5,000.00. The additional benefit provides payment for the Usual and Customary Expenses incurred within 2 years from the date of covered accident for treatment, repair and replacement of each injured natural tooth; including examination, diagnosis, x-ray, restorative treatment, endodontics, and oral surgery, plus for the replacement of caps, crowns, dentures, and orthodontic appliances. **COVERAGE IS IN EFFECT 24 HOURS A DAY, EVEN WHEN SELECTED WITH SCHOOL TIME ONLY COVERAGE.** If there is more than one option for treating a dental problem, the company will pay benefits for the least expensive procedure, provided that it meets acceptable dental standards.
Beneficio de tratamiento dental por accidentes: Al agregar una prima adicional a las tarifas del plan básico, se pueden extender los beneficios dentales bajo el máximo beneficio general para proveer pago de gastos cubiertos hasta un máximo de $5,000.00. El beneficio adicional proporciona pago por los Gastos usuales y acostumbrados incurridos dentro de 2 años a partir de la fecha del accidente cubierto para tratamiento, reparación y reemplazo de cada diente natural lesionado; incluyendo examen, diagnosis, rayos X, tratamiento restaurador, endodoncia y cirugía bucal, además del reemplazo de tapas, coronas, dentaduras postizas y aparatos de ortodoncia. **LA COBERTURA ESTÁ EN VIGOR LAS 24 HORAS AL DÍA, AUN CUANDO SE SELECCIONE COBERTURA DURANTE EL HORARIO DE CLASES SOLAMENTE.** Si existe más de una opción para tratar un problema dental, la compañía pagará beneficios por el procedimiento menos caro, siempre y cuando cumpla con los estándares aceptables de odontología.

CLAIMS PROCEDURE: In case of accident, notify school immediately. Obtain a claim form from your school or at www.studentinsuranceplans.com and mail to the address indicated on the claim form. **NOTICE OF CLAIM MUST BE FILED WITHIN 90 DAYS FROM DATE OF ACCIDENT.**
PROCEDIMIENTO DE RECLAMACIONES: En caso de accidente, notifique inmediatamente a la escuela. Obtenga un formulario de reclamación de su escuela o visitando www.studentinsuranceplans.com y envíelo a la dirección indicada en el formulario. **EL AVISO DE RECLAMACIÓN DEBE PRESENTARSE DENTRO DE LOS 90 DÍAS CONTADOS A PARTIR DEL ACCIDENTE.**

Benefits subject to the terms and conditions of the insurance policy issued on behalf of Catlin Insurance Company, Inc., Houston, TX to the school; please contact the school for a copy of this policy.
Los beneficios están sujetos a los términos y condiciones de la póliza de seguros emitida en nombre de Catlin Insurance Company, Inc., Houston, TX a la escuela; favor de contactar a la escuela para obtener una copia de esta póliza.

DM-C-TX

Texas Student Resources

Student Athletic/Activities Insurance

Liberty Mutual / 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

2014-15 Student Insurance **Proposal for Mineola ISD**

Liberty Mutual Accident & Health

BLANKET AHLETICS & ACTIVITIES COVERAGE

Coverage Option	Grades	Plan Option	Premium
All UIL Athletics & Activities	PK-12	Premier Plan*	$33,583.00
	PK-12	Premier Plus*	$42,177.00
	PK-12	80% U&C Plan*	$43,819.00

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 (Excludes 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:** Catastrophic Coverage **$7,500,000**
Post Injury **Concussion** Management Testing
Ambulance **Ground or Air** 100% U&C (first trip).

Claims administered and paid locally in Texas (Health Special Risk 866 409-5734).
Voluntary Accident Plan available to students (Underwritten by (Liberty Mutual).
Visit our Website: www.K12StudentInsurance.com

CATASTROPHIC COVERAGE (Underwritten by Liberty Mutual).
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				$ 976.00
Total (if Catastrophic Cash Benefit Selected)				$2,584.00

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 Mutual
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

Premier – Mandatory

Full Excess Accident Expense Benefit Maximum	$25,000
First Covered Expenses must be received within	60 days after the Covered Injury
Benefit Period	1 year from the date of the Covered Injury
Benefit Limit for Covered Injuries from any one motor vehicle Accident	$5,000
INPATIENT HOSPITAL SERVICES	
Room and Board Expenses	
Semi-Private Room	100% of the Usual and Customary Charges
Intensive Care Unit/Critical Care Unit	1.5 times the daily semi–private room rate
Hospital Miscellaneous Expenses	up to $250 per day to a maximum of $5,000 per Covered Injury
Emergency Room Treatment	up to $150 per Covered Injury
Emergency Room Treatment must occur within	72 hours of the Covered Injury
Registered Nursing Services	up to $400 per Covered Injury
Physician Services	
Surgery	75% of the Usual and Customary Charges up to $3,750 per Covered Injury
Assistant Surgeon	25% of Physician's Surgery Allowance
Anesthesia and its Administration	25% of Physician's Surgery Allowance
Physician In-Hospital Non –Surgical Visits	up to $40 per visit
OUTPATIENT BENEFITS	
Physician Office Non- Surgical Visits	up to $40 per visit
Combined Maximum for CT scan, MRI	up to $500 per Covered Injury
Reading amount	up to $25 per Covered Injury
X-ray	up to $200 per Covered Injury
X-ray reading	up to $25 per Covered Injury
Laboratory tests	up to $50 per Covered Injury
Outpatient Physiotherapy Benefit	up to 5 treatments; up to $125 per Covered Injury; 1 visit in a day
Outpatient Orthopedic Appliances	up to $500 per Covered Injury
Hospital Outpatient Surgery Facilities Payment	up to $1,500 per Covered Injury
Ambulance Services	100% of the Usual and Customary Charges
Medical Equipment	up to $150 per Covered Injury
Dental Services	up to $250 per tooth
Outpatient Prescription Drugs	100% of the Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	100% of the Usual and Customary Charges
Post Injury Concussion Testing	up to $25 per Covered Injury

Premier Plus – Mandatory

Full Excess Accident Expense Benefit Maximum	$25,000
First Covered Expenses must be received within	60 days after the Covered Injury
Benefit Period	1 year from the date of the Covered Injury
Benefit Limit for Covered Injuries from any one motor vehicle Accident	$5,000
INPATIENT HOSPITAL SERVICES	
Room and Board Expenses	
Semi-Private Room	100% of the Usual and Customary Charges
Intensive Care Unit/Critical Care Unit	1.5 times the daily semi–private room rate
Hospital Miscellaneous Expenses	up to $750 first day, $250 per day thereafter to a maximum of $5,000 per Covered Injury
Emergency Room Treatment	up to $350 per Covered Injury
Emergency Room Treatment must occur within	72 hours of the Covered Injury
Registered Nursing Services	100% of the Usual and Customary Charges
Physician Services	
Surgery	90% of the Usual and Customary Charges up to $4,500 per Covered Injury
Assistant Surgeon	25% of Physician's Surgery Allowance
Anesthesia and its Administration	25% of Physician's Surgery Allowance
Physician In-Hospital Non –Surgical Visits	up to $40 per visit
OUTPATIENT BENEFITS	
Physician Office Non- Surgical Visits	up to $40 per visit
Combined Maximum for CT scan, MRI	up to $750 per Covered Injury
Reading amount	up to $50 per Covered Injury
X-ray	up to $200 per Covered Injury
X-ray reading	up to $50 per Covered Injury
Laboratory tests	up to $50 per Covered Injury
Outpatient Physiotherapy Benefit	up to 10 treatments; up to $250 per Covered Injury; 1 visit in a day
Outpatient Orthopedic Appliances	up to $500 per Covered Injury
Hospital Outpatient Surgery Facilities Payment	up to $2,000 per Covered Injury
Ambulance Services	100% of the Usual and Customary Charges
Medical Equipment	up to $150 per Covered Injury
Dental Services	100% of the Usual and Customary Charges
Outpatient Prescription Drugs	100% of the Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	100% of the Usual and Customary Charges
Post Injury Concussion Testing	up to $50 per Covered Injury

80% U&C – Mandatory

Full Excess Accident Expense Benefit Maximum	$25,000
First Covered Expenses must be received within	60 days after the Covered Injury
Benefit Period	1 year from the date of the Covered Injury
Benefit Limit for Covered Injuries from any one motor vehicle Accident	$5,000
INPATIENT HOSPITAL SERVICES	
Room and Board Expenses	
Semi-Private Room	80% of the Usual and Customary Charges
Intensive Care Unit/Critical Care Unit	80% of the Usual and Customary Charges
Hospital Miscellaneous Expenses	80% of the Usual and Customary Charges
Emergency Room Treatment	up to $500 per Covered Injury
Emergency Room Treatment must occur within	72 hours of the Covered Injury
Registered Nursing Services	80% of the Usual and Customary Charges
Physician Services	
Surgery	80% of the Usual and Customary Charges up to $5,000 per Covered Injury
Assistant Surgeon	25% of Physician's Surgery Allowance
Anesthesia and its Administration	25% of Physician's Surgery Allowance
Physician In-Hospital Non –Surgical Visits	80% of the Usual and Customary Charges
OUTPATIENT BENEFITS	
Physician Office Non- Surgical Visits	80% of the Usual and Customary Charges up to 5 visits
Combined Maximum for CT scan, MRI	up to $1,200 per Covered Injury (includes reading)
X-ray	up to $300 per Covered Injury (includes reading)
Laboratory tests	80% of the Usual and Customary Charges
Outpatient Physiotherapy Benefit	up to 20 treatments; up to $1,000 per Covered Injury; 1 visit in a day
Outpatient Orthopedic Appliances	up to $600 per Covered Injury
Hospital Outpatient Surgery Facilities Payment	up to $3,500 per Covered Injury
Ambulance Services	80% of the Usual and Customary Charges
Medical Equipment	up to $150 per Covered Injury
Dental Services	80% of the Usual and Customary Charges
Outpatient Prescription Drugs	80% of the Usual and Customary Charges
Eyeglasses, Contact Lenses, Hearing Aids	80% of the Usual and Customary Charges
Post Injury Concussion Testing	up to $75 per Covered Injury

CATASTROPHE MEDICAL ONLY: Plan D	
Full Excess Accident Expense Benefit Maximum	$7,500,000
First Covered Expenses must be received within	730 days after the Covered Injury
Catastrophic Benefit Period	The earliest of the Date of Recovery or 10 years from the date of the Covered Injury
Catastrophic Accident Medical Deductible	$25,000 applies to each Covered Injury
Catastrophic Accident Medical Deductible must be satisfied within	24 months of the Covered Injury
INPATIENT HOSPITAL SERVICES	
Room and Board Expenses	
Semi-Private Room	average semi-private room rate
Inpatient Mental and Nervous Disorders	
Hospital Expenses Benefit Amount	100% of the Usual and Customary Charge
Maximum Days of Hospital Confinement	45 days
OUTPATIENT BENEFITS	
Outpatient Physiotherapy Benefit	
Benefit Amount	up to $25,000 per Calendar Year
Covered physiotherapy services	(a) acupuncture; (b) microthermy; (c) manipulation; (d) diathermy; (e) massage therapy; (f) heat treatment; and (g) ultrasonic treatment)
Chiropractic Treatment Benefit	up to $1,000 per Calendar Year
Outpatient Mental and Nervous Disorders	
Physician Expenses	up to $50 per day, up to 50 visits per Calendar Year
Artificial Limbs	up to $200,000 per Covered Injury If amputation of the leg above the knee $300,000
Extended Care Facility	up to$365,000 per Calendar Year
Must begin within	5 days after the Insured Person has been continually Hospital Confined for 5 days

Allocated Cash: Plan D	
Full Excess Accident Expense benefit Maximum	$7,500,000
First Covered Expenses must be received within	730 days after the Covered Injury
Catastrophic Benefit Period	The earliest of the Date of Recovery or 10 years from the date of the Covered Injury
Catastrophic Accident Medical Deductible	$25,000 applies to each Covered Injury
Catastrophic Accident Medical Deductible must be satisfied within	24 months of the Covered Injury
INPATIENT HOSPITAL SERVICES	
Room and Board Expenses	
Semi-Private Room	average semi-private room rate
Intensive Care Unit/Critical Care Unit	1.5 times the daily semi –private room rate
Hospital Miscellaneous Expenses	100% of the Usual and Customary Charges
Registered Nursing Services	100% of the Usual and Customary Charges
Physician Services	
Surgery	100% of the Usual and Customary Charges
Assistant Surgeon	100% of the Usual and Customary Charges
Anesthesia and its Administration	100% of the Usual and Customary Charges
Inpatient Mental and Nervous Disorders	
Hospital Expenses Benefit Amount	100% of the Usual and Customary Charges
Maximum Days of Hospital Confinement	45 days
OUTPATIENT BENEFITS	
Outpatient Physiotherapy Benefit	
Benefit Amount	up to $25,000 per Calendar Year
Covered physiotherapy services	(a) acupuncture; (b) microthermy; (c) manipulation; (d) diathermy; (e) massage therapy; (f) heat treatment; and (g) ultrasonic treatment)
Chiropractic Treatment Benefit	up to $1,000 per Calendar Year
Outpatient Mental and Nervous Disorders	
Physician Expenses	up to $50 per day, up to 50 visits per Calendar Year
Artificial Limbs	up to $200,000 per Covered Injury If amputation of the leg above the knee $300,000
Extended Care Facility	up to$365,000 per Calendar Year
Must begin within	7 days after the Insured Person has been continually Hospital Confined for 7 days
Home Health Care Benefit	up to $100,000 per Calendar Year
Must begin within	7 days after the Insured Person has been continually confined for 7 days in Hospital or Extended Care Facility or Rehabilitation Facility
Custodial Care Benefit	up to$100,000 per Calendar Year
Combined Home Health Care, Custodial Care Maximum Benefit	up to$100,000 per Calendar Year

2014-2015
TEXAS K-12 INSURANCE
Rate Schedule

PREMIER VOLUNTARY PLAN

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).

With Extended Dental	$205.00 Per Student
Without Extended Dental	$196.00 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).

With Extended Dental	$103.00 Per Student
Without Extended Dental	$94.00 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.

With Extended Dental	$300.00 Per Student
Without Extended Dental	$291.00 Per Student
Spring Football With Extended Dental	$125.00 Per Student
Spring Football Without Extended Dental	$116.00 Per Student

Extended Dental Coverage: This is supplemental coverage for expenses resulting from covered accidental dental injuries. The dental benefits provided are: (a) 100% of U&C Charges for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000; or (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.

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.

ECONOMY VOLUNTARY PLAN

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).

With Extended Dental	$137.00 Per Student
Without Extended Dental	$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).

With Extended Dental	$73.00 Per Student
Without Extended Dental	$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.

With Extended Dental	$198.00 Per Student
Without Extended Dental	$189.00 Per Student
Spring Football With Extended Dental	$85.00 Per Student
Spring Football Without Extended Dental	$76.00 Per Student

Extended Dental Coverage: This is supplemental coverage for expenses resulting from covered accidental dental injuries. The dental benefits provided are: (a) 100% of U&C Charges for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000; or (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.

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.

VOLUNTARY PLAN

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