STARR COMPANIES | HSR Health Special Risk, Inc.

Voluntary Student Accident Insurance

Texas

HSR is an independent licensed insurance agency and is authorized to sell this student accident insurance on behalf of Starr Companies . Coverage underwritten by: Starr Indemnity & Liability Co., Dallas, TX

Health Special Risk, Inc.
HSR Plaza II
4100 Medical Parkway, Suite 200
Carrollton, TX 75007 - 1517
Phone: 866.409.5733, Ext. 5660
Fax: 972.512.5819
www.healthspecialrisk.com

TEXAS

K-12 Voluntary Student Accident Insurance Coverage
Policy Form AH-20001-TX-EDU
Coverage underwritten by: Starr Indemnity & Liability Co., Dallas, TX

Eligibility

All registered students of a participating school/district in grades Pre K-12.

Coverages

Option A: 24 Hour Coverage excluding High School Football: Coverage is provided at all times except while participating in any activity, including tryouts, practice or any competitions or games for high school football.

Option B: At School Coverage excluding High School Football: Coverage is provided during 1. Regularly scheduled classroom instruction; 2. regularly scheduled and supervised recess or lunch period; or 3. a study period or special instruction period supervised by a member of the School's faculty. Coverage is also provided during School sponsored interscholastic sports and activities. High school football is not covered.

Option C: High School Football only: Coverage is provided during: 1. regularly scheduled practice or training; 2. regularly scheduled competition or exhibition game; or 3. a scheduled tryout, workout session or team meeting.

Benefits

Accident Medical Expense: The Company will be for the Covered Expenses that result directly, and from no other cause, from a Covered Accident, provided that the first Covered Expense is incurred within 60 days of the Covered Accident. To be eligible for payment, Covered Expenses must be incurred within 365 days of the Covered Accident. Payment of benefits are subject to the Deductibles, Coinsurance Factors, Co-payments, Benefit Periods, Benefit Maximums that are shown in the Schedule of Benefits, below. Benefits for any one accident shall not exceed the Accidental Medical Expense Maximum of $25,000.

Covered Expenses include the following:

- Room and Board in a Semi-Private room;
- Hospital Miscellaneous Services;
- Physician services, Surgery, Assistant Surgeon, Physician's Surgical Facilities, Anesthesia and it's administration, In Hospital Physician Visits, Physician Office Visits;
- Emergency Room;
- Outpatient Services**;**
- Outpatient X Ray, CT Scan**,** MRI, and Laboratory Test includes charges for reading;
- Outpatient Physiotherapy;
- Orthopedic Appliances
- Ambulance Services: one trip to the nearest Hospital by air or ground**;**
- Dental Services provided by a Dentist or Physician;
- Outpatient Prescription Drugs;
- Eyeglasses, Contacts Lenses and Hearing Aids;
- Medical equipment rental if less than the purchase of equipment;
- Treatment of Heat Exhaustion

Full Excess Medical Expense: Covered Expenses shall only be payable if they are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

Failure by a Covered Person to follow the terms and conditions of his primary coverage will result in a benefit reduction of eligible expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by his primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

Extended Dental Coverage (Available only when selected): This is supplemental coverage for expenses resulting from covered accidental dental injuries. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof. If Extended Dental Coverage is selected, Dental x-rays, endodontic and Oral Surgery are covered up to $10,000 per Covered Accident. Bridges, dentures or replacement of dental repairs are covered up to $250 per Covered Accident. The benefit period for this benefit is 52 weeks.

Accidental Death, Dismemberment, or Loss of Sight, Speech or Hearing: If Injury to the Covered Person results in any of the losses shown below, within 365 days from the date of the Covered Accident that caused the Injury, the Company will pay the amount shown below for that loss. If multiple losses occur as a result of the same Covered Accident, only one benefit, the largest, will be paid for all losses due to that Covered Accident.

Loss of Life	$2,000
Loss of Two or More Members	$10,000
Loss of One Member	$5,000
Loss of Thumb and Index Finger of the Same Hand	$500

"Member" means Loss of Hand or Foot and Loss of Sight. "Loss of a Hand or Foot" means complete severance through or above the wrist or ankle joint. "Loss of Sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of Thumb and Index Finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means.

Definitions

Accident means a sudden, unexpected event that results in Injury to the Covered Person.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in an Injury for which benefits are payable.

Covered Person means an Insured while participating in a Hazard.

Deductible means the dollar amount of Covered Expenses that has to be incurred and paid prior to the Accident Medical Expense Benefit being paid. The Deductible amount is shown in the Schedule of Benefits and is satisfied by amounts paid by the Covered Person or amounts paid by another Health Care Plan.

Hazard means an activity for which coverage is afforded under this insurance. The Hazards are contained in the Coverage section. Note that the Hazard(s) may be different for each option.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under: 1) group or blanket insurance, whether on an insured or self-funded basis; 2) Hospital or medical service organizations on a group basis; 3) Health Maintenance Organizations on a group basis; 4) group labor management plans; 5) employee benefit organization plan; 6) professional association plans on a group basis; 7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or 8) automobile no-fault coverage (unless prohibited by law).

Hospital means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons; 2) provides 24-hour nursing service by registered nurses on duty or call; 3) has a staff of one or more licensed physicians available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and) is not a place for drug addicts, alcoholics or the aged. We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following: 1) the Joint Commission of Accreditation of Hospitals; or 2) the American Osteopathic Association; or 3) the Commission on the Accreditation of Rehabilitative Facilities.

Hospital Miscellaneous Expenses means the Medically Necessary expenses charged by a Hospital or Ambulatory Surgical Center for Outpatient surgery. The Miscellaneous Expenses include, but are not limited to, the expenses shown in the Schedule of Benefits and all necessary charges other than room and board, for services received during a Hospital stay.

Injury means bodily injury to a Covered Person that is the direct result, independent of all other causes, of a Covered Accident. occurring while the Policy is in force as to the person whose injury is the basis of the claim.

Insured means a person who is eligible for coverage and for whom the required premium is paid.

Medically Necessary means a treatment, service or supply that is: 1) required to treat an Injury; 2) prescribed or ordered by a Physician or furnished by a Hospital; 3) performed in the least costly setting required by the condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

Pre-existing Condition means an illness, disease or other condition of the Covered Person, that in the 6 month period before the Covered Person's coverage became effective under the Policy: 1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or 2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3) was treated by a Physician or treatment had been recommended by a Physician.

Usual and Customary Charges means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Filing a Claim

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company, care of **Health Special Risk, Inc., HSR Plaza II, 4100 Medical Parkway, Carrollton, TX 7500,** Attn: Claims Department. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 90 days after the date of loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if: 1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death. All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions.'

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company has the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. The Insurance Company also has the right to request an autopsy in the case of death, unless the law forbids it. The Company will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, the Company has the right to recover the amount overpaid or paid in error by any of the following methods: 1) A request for lump sum payment of the amount overpaid or paid in error, or 2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party. The Company agrees to pay its portion of the Policyholder's reasonable attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its subrogation right.

Exclusions and Limitations

This Policy does not cover:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane; 2.Any injury or sickness caused during the Covered Person's commission of a felony; 3. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances; 4. War or any act of war, declared or undeclared war; 5. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician; 6. Covered expenses for which the Covered Person would not be responsible in the absence of the Policy; 7. Injuries paid under workers' compensation, employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder; 8. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician; 9. Service or active duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization; 10. Services or treatment rendered by a Physician, nurse or any other person who is employed or retained by the Policyholder or an immediate family member of the Covered Person; 11. Treatment of a hernia, Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a covered accident; 12. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided by the Policy; 13. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.

The following will not be considered covered expenses unless coverage is specifically provided in the Policy: 1. Blood, blood plasma, or blood storage, except expenses by a Hospital for processing or administration of blood. 2. Cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Loss. 3. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States. 4. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay. 5. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay. 6. Rest cures or custodial care. 7. Personal services such as television and telephone or transportation. 8. Orthopedic appliances used mainly to protect an Injury so that the Covered Person can take part in interscholastic and club sports. 9. Expenses payable by any automobile insurance policy without regard to fault. 10. Treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity. 11. Repair or replacement of existing artificial limbs, eyes and larynx. 12. Charges for any article of clothing intended for use more than once. 13. Pre-Existing Conditions, as defined herein. 14. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions. This does not apply if treatment is required as a result of a Covered Accident. 15. Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial pain. 16. Injury or death to which a contributing cause is the Covered Person's violation or attempt to violate any duly-enacted law or the commission or attempt to commit an assault or a felony. 17. Eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof, unless caused by an Injury incurred while covered under the Policy. 18. Mental and Nervous Disorders. 19. Home Health Care.

NOTE: ***This brochure provides a summary of the insurance coverage and does not contain the complete terms and conditions of the insurance policy. All information herein is subject to the provisions of the insurance policy underwritten by Starr Indemnity & Liability Company. If there is any conflict between the brochure and the policy, policy provisions will prevail. For a copy of the insurance policy contact Health Special Risk, Inc.***

Texas Voluntary Student Accident Insurance Schedule of Benefits

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 Accident	60 days after the Covered Accident
Benefit Period	1 year from the date of the Covered Accident	1 year from the date of the Covered Accident
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 / Critical Care	1.5 times the Semi-Private Room Rate	1.5 times the Semi-Private Room Rate
Hospital Miscellaneous Expenses	up to $250 per day, to a maximum of $4,000 per Covered Accident	up to $250 per day to a maximum of $5,000 per Covered Accident
Emergency Room Treatment	up to $75 per Covered Accident	up to $150 per Covered Accident
Emergency Room Treatment must occur within	72 hours of the Covered Accident	72 hours of the Covered Accident
Registered Nursing Services	up to $400 per Covered Accident	up to $400 per Covered Accident
Physician Services		
Surgery	75% of the Usual and Customary Charges up to $3,500 per Covered Accident	75% of the Usual and Customary Charges up to $3,750 per Covered Accident
Assistant Surgeon	25% of Surgery Allowance	25% of Surgery Allowance
Anesthesia and its Administration	25% of Surgery Allowance	25% of Surgery Allowance
Physician In-Hospital Non –Surgical Visits	up to $20 per visit/1 visit per day	up to $40 per visit/1 visit per day
OUTPATIENT BENEFITS		
Physician Office Non- Surgical Visits	up to $20 per visit/1 visit per day	up to $40 per visit/1 visit per day
Emergency Room Physician	Up to $40 per Covered Accident	Up to $60 per Covered Accident
Combined Maximum for CT scan, MRI	up to $250 per Covered Accident	up to $500 per Covered Accident
X-ray	up to $100 per Covered Accident	up to $200 per Covered Accident
Laboratory tests	up to $25 per Covered Accident	up to $50 per Covered Accident
Outpatient Physiotherapy Benefit	up to 2 treatments; up to $40 per Covered ; 1 visit in a day	up to 5 treatments; up to $100 per Covered Accident; 1 visit in a day
Outpatient Orthopedic Appliances	up to $300 per Covered Accident	up to $300 per Covered Accident
Post-Surgical Medical Equipment	up to $150 per Covered Accident	up to $150 per Covered Accident
Shots & Injections	Up to $25 per Covered Accident	Up to $25 per Covered Accident
Outpatient Prescription Drugs	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Hospital Outpatient Surgery Facilities Payment	up to $750 per Covered Accident	up to $1,250 per Covered Accident
INPATIENT AND OUTPATIENT BENEFITS		
Ambulance – 1 trip to nearest Hospital	up to $100 per Covered Accident	100% of the Usual and Customary Charges
Dental Services (sound natural teeth only)	up to $150 per Tooth	up to $250 per tooth
Eyeglasses, Contact Lenses, Hearing Aids	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
Treatment of Heat Exhaustion	100% of the Usual and Customary Charges	100% of the Usual and Customary Charges
AVAILABLE ONLY WHEN SELECTED		
Extended Dental	up to $10,000 per Covered Accident; Cost of bridges, dentures, or replacement of dental repairs up to $250 per Covered Accident; 52 week benefit period	up to $10,000 per Covered Accident; Cost of bridges, dentures, or replacement of dental repairs up to $250 per Covered Accident; 52 week benefit period

Plan & Rate Options

	without Extended Dental		with Extended Dental	
	Economy	Premier	Economy	Premier
Option A 24 Hour without HS Football	$98.00	$150.00	$105.00	$158.00
Option B At School without HS Football	$49.00	$72.00	$56.00	$79.00
Option C High School Football	$161.00	$247.00	$169.00	$255.00
Option C Spring High School Football	$65.00	$99.00	$73.00	$107.00

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

VOLUNTARY STUDENT ACCIDENT INSURANCE ENROLLMENT FORM

Student's Last Name _____ Student's DOB (MM-DD-YYYY) _____

Student's First Name _____ MI _____ Telephone Number _____

Student's Social Security Number _____ Grade _____ Student Identification Number _____

Street # _____ Address _____

City _____ State _____ Zip Code _____

Name of School District _____ Name of School/Campus (required to process) _____

Signature of Parent/Guardian _____ Date _____

Email Address _____

Please select your Plan below:

	Without Extended Dental				With Extended Dental			
	Economy*		Premier*		Economy*		Premier*	
Option A 24 Hour without HS Football		$98.00		$150.00		$105.00		$158.00
Option B At School without HS Football		$49.00		$72.00		$56.00		$79.00
Option C High School Football		$161.00		$247.00		$169.00		$255.00
Option C Spring High School Football		$65.00		$99.00		$73.00		$107.00
Company Use ONLY: **Check #:**	**Enclose check for total amount payable to:** ***Health Special Risk*** TOTAL All Selections HERE:							
Amt Rec'd:								

* There is a $1.00 administration fee due with each paper enrollment form submission.

Once completed, mail this form to:

HSR K12 Voluntary Account
P.O. Box 957824 St. Louis, MO 63195-7824

For more information or assistance regarding all Student Insurance, contact our Customer Service Department at **866-409-5733.**

IF YOU WISH TO PAY WITH MASTERCARD OR VISA: Go to www.K12StudentInsurance.com**

A 5% administrative charge will be added for Credit Card Orders

. The Master policy is the contract and will govern and control the payment of benefits. **Coverage underwritten by: Starr Indemnity & Liability Company, Dallas, TX**