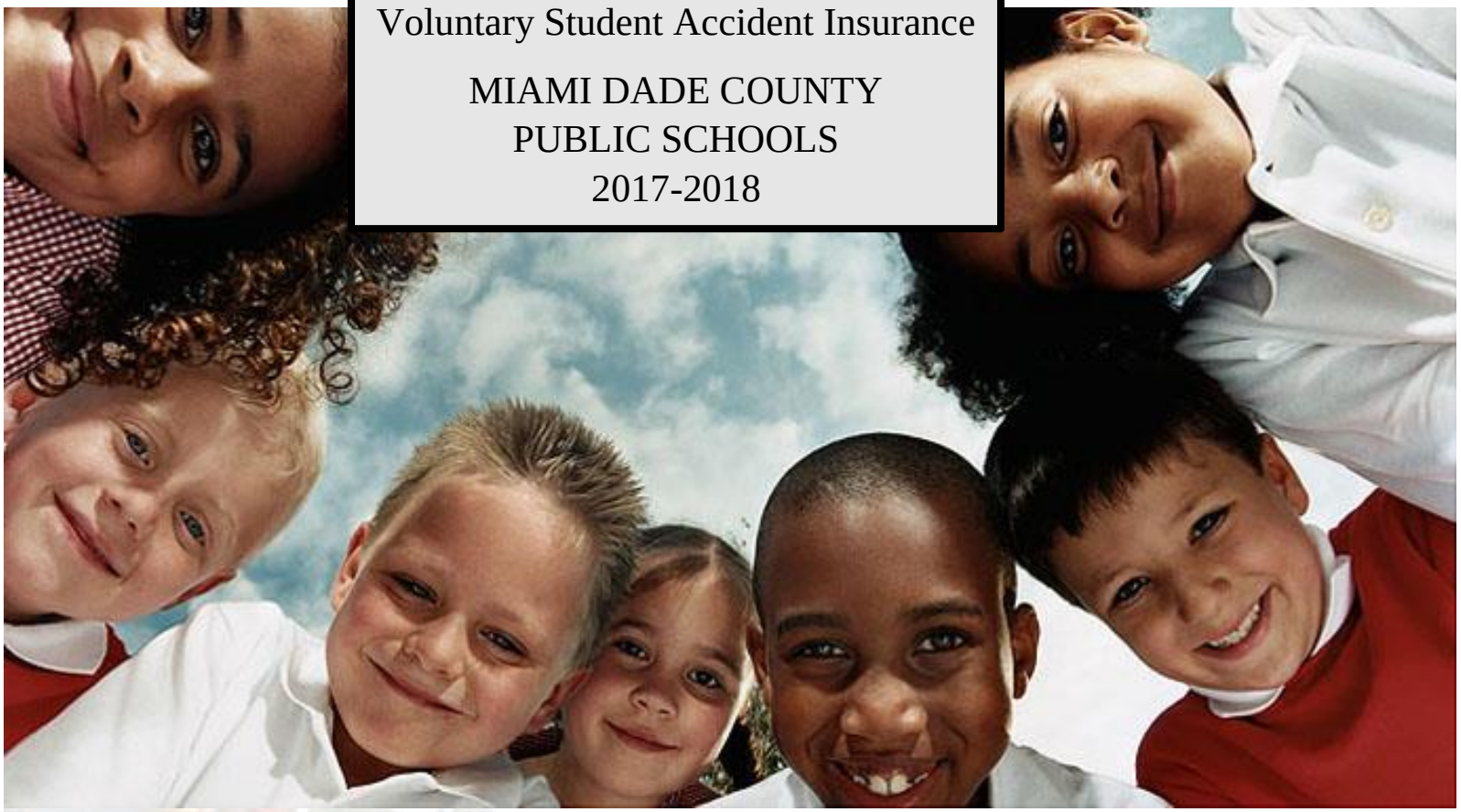
Voluntary Student Accident Insurance

MIAMI DADE COUNTY PUBLIC SCHOOLS 2017-2018



Plan Administrator

HSR
Health Special Risk, Inc.

Health Special Risk, Inc.
HSR Plaza II
4100 Medical Pkwy., Suite 200
Carrollton, TX 75007-1517

Toll-free: 866.409.5733, ext. 5660
Fax: 972.512.5819
www.healthspecialrisk.com

HSR is an independent licensed insurance agency and is authorized to sell this student accident insurance on behalf of Starr Companies.

Offered Through

ifs

Insurance for Students, Inc.
1690 South Congress Ave, Suite 101
Delray, FL 33445

Phone: 954.771.5883
Toll-free: 800.356.1235
Fax: 954.772.0872
ifs@insuranceforstudents.com

Underwritten By

STARR
INDEMNITY & LIABILITY

Starr Indemnity & Liability Company
New York, NY 10022

Policy Number: BAP 273187

HSR
Health Special Risk, Inc.

2017-2018

MIAMI DADE COUNTY PUBLIC SCHOOLS

K-12 Voluntary Student Accident Insurance Coverage

Coverage underwritten by: Starr Indemnity & Liability Company;
399 Park Avenue, 8th Floor, New York, NY 10022

This is only a brief description of the coverage(s) available under Policy Number BAP 273187. The policy will contain reductions, limitations, exclusions, and termination provisions. Full details of the coverage are contained in the policy. If there are any conflicts of discrepancies between this document and the policy or if any point is not covered in this document, the terms and conditions of the policy shall govern. Capitalized terms not defined herein are defined in the policy.

ELIGIBILITY:

All registered students grades PreK-12 of a participating school/district.

COVERAGE OPTIONS

24-HOUR COVERAGE: Benefits will be paid for injuries sustained 24-hours a day, 365 days a year; during School breaks, summer School and summer vacation. No coverage is provided while participating in the practice or play of High School Interscholastic Football.

AT SCHOOL COVERAGE: Benefits will be paid for injuries sustained: (a) during the regular School term; (b) on School premises during the hours when School is in session; (c) on School premises during the hours when School is not in session if participating in or attending any School sponsored event or activity; (d) away from School premises while participating in or attending any School sponsored event/activity (to include one day field trips); (e) traveling directly to or from the Insured's residence and the School premises on days when the Insured has regularly scheduled classes; if travel is by any mode of transportation other than School bus, covered travel time is one hour before the first class and one hour after the Insured is dismissed; and (e) traveling to, during or after a covered event/activity as a member of a group in transportation furnished or arranged by the Policyholder School/district. No coverage is provided while participating in the practice or play of High School Interscholastic Football.

COVERAGE PERIOD – Coverage under the At School and 24-Hour programs begins on the date of premium receipt but not before the start of the school year activities. At School Coverage ends at the close of the regular nine-month school term, except for events sponsored and supervised by the school during the summer. 24-Hour Coverage ends when school reopens for the following fall term. Coverage is available under both plans throughout the school year at the premiums quoted **(no pro rata premiums available).**

BENEFITS

ACCIDENT MEDICAL EXPENSE: When a covered injury to an Insured results in treatment by a physician or surgeon beginning within 60 days of the date of the accident; we will pay benefits as shown in the **Schedule of Benefits**, in excess of the Medical Deductible, if any. Only eligible medical expenses incurred by the Insured within 104 weeks from the date of the accident are covered. Benefits for any one accident shall not exceed the maximum Medical Benefit of $25,000 ($5,000 for Motor Vehicle Accidents, other than 2 or 3 wheeled). We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period.

ACCIDENTAL DEATH AND DISMEMBERMENT: If injury to the Insured in any of the Covered Losses shown below, within 180 days from the date of Injury, the Company will pay the amount indicated below for that Loss. If multiple losses occur, only one Benefit, the largest will be paid for all Losses due to the same Covered Accident.

Loss of Life	$1,500.00
Loss of both hands, both feet, sight in both eyes, speech and hearing	$7,500.00
Loss of one hand, one foot, sight in one eye, speech or hearing	$1,000.00
Loss of Thumb and Index Finger of the Same Hand	$500.00

DEFINITIONS

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.

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.

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 6) 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.

EXCLUSIONS AND LIMITATIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of, any of the following even if the immediate cause of the loss is an accidental bodily injury: Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane; War or any act of war, declared or undeclared; 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; Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician; Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy; 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; 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; 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; 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; 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; Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy; Eyeglasses, contact lenses, hearing aids; 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 Schedule of Benefits:
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). Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices; 5) Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay; 6) Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay; 7) Rest cures or custodial care; 8) Repair or replacement of existing dentures, partial dentures, braces or bridgework; 9)Personal services such as television and telephone or transportation; 10)Orthopedic appliances used mainly to protect an Injury so that the Covered Person can take part in interscholastic and club sports; 11) Expenses payable by any automobile insurance policy without regard to fault; 12) 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; 13) Repair or replacement of existing artificial limbs, eyes and larynx; 14) Charges for any article of clothing intended for use more than once; 15)Pre-Existing Conditions, as defined herein; 16) pregnancy, childbirth, miscarriage, abortion or any complications of any of these condition unless required as a result of a Covered Accident; 17) expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain; 18) 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; 19) eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, examinations or prescriptions for them or repair or replacement of existing artificial limbs, orthopedic braces or orthotic devices; 20) treatment or service provided by a private duty nurse; 21) 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; 22) Shots/Injections; 23) Mental and Nervous Disorders; 24) travel in or upon any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated; 25) injuries associated with activities or travel outside the United States.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS. Retain this student accident insurance flyer, and your canceled check or money order receipt as your record of coverage. This flyer has been designed to illustrate the highlights of this insurance. All student accident insurance information is subject to the provisions of Policy Form AH-20001-FL.

STUDENT ACCIDENT INSURANCE SCHEDULE OF BENEFITS

INPATIENT:	BASIC PLAN
Room & Board	100% of Usual & Customary Charges up to $1,000 per day
Hospital Miscellaneous	100% of Usual & Customary Charges up to AME Limit
Registered Nurse	100% of Usual & Customary Charges up to AME Limit
Physician's Nonsurgical Visits	Up to $45 first day; $40 per day thereafter (limited to one visit per day)
OUTPATIENT:	
Hospital Outpatient Surgery – Facility Charge	100% of Usual & Customary Charges up to AME Limit
Physician's Nonsurgical Visits	Up to $45 first day; $40 per day thereafter (limited to one visit per day)
Physiotherapy	Up to $30 per visit/10 visit maximum
Emergency Room	100% of Usual & Customary Charges up to AME Limit (treatment must be rendered within 72 hours from time of injury)
X-Ray Services (includes charges for reading)	100% of Usual & Customary Charges up to $75 maximum
Cat Scan (includes charges for reading)	100% of Usual & Customary Charges up to $375 maximum
MRI (includes charges for reading)	100% of Usual & Customary Charges up to $750 maximum
Laboratory	No Benefits
Injections	No Benefits
Prescription Drugs	No Benefits
Heart & Circulatory (Covered Condition: Heat Exhaustion)	100% of Usual & Customary Charges up to AME Limit
Orthopedic Braces and Appliances	100% of Usual & Customary Charges up to $250 maximum
INPATIENT AND/OR OUTPATIENT:	
Surgeon's Fees	100% of Usual & Customary Charges up to AME Limit
Anesthetist	100% of Usual & Customary Charges up to AME Limit
Assistant Surgeon	100% of Usual & Customary Charges up to AME Limit
Ambulance (from accident site to hospital)	100% of Usual & Customary Charges up to $250 maximum
Consultant	Paid under Physician's visit
Dental (injury to sound, natural teeth only, including X-rays)	Up to $500 per tooth/$1,000 maximum
Replacement of Eyeglasses, Contact Lenses and Hearing Aids	100% of Usual & Customary Charges up to AME Limit (When broken as a result of a covered injury)
Home Health Care	40 non-surgical visits per policy year (Services must be rendered within 7 days after hospital stay or outpatient surgery. Physician must recommend treatment)
Blood Borne Pathogen Exposure Expense Benefit	100% of Usual & Customary Charges up to $500 maximum
Food Poisoning	Paid as any other Injury (Food Poisoning must be caused by school supplied food)

PLAN & RATE OPTIONS

(Make your selection on the enrollment form attached).

COVERAGE PLANS	BASIC PLAN
24-Hour excluding High School Football (PK-12)	$73.00
At School excluding Athletics/Football (PK-6)	$15.00
At School (grades 7-12) excluding Senior High Interscholastic Athletics & Football	$16.00

2017-2018
MIAMI DADE COUNTY PUBLIC SCHOOLS
K-12 VOLUNTARY STUDENT ACCIDENT INSURANCE
ENROLLMENT FORM

Student's Last Name: _____ Student's Date of Birth: _____

Student's First Name: _____ MI: _____ Telephone Number: _____

Student's Social Security Number: _____ Grade: _____ Student ID Number: _____

Address: _____
Street City State Zip

Name of School District: _____ Name of School Campus: _____
(**Required to Process**)

Signature of Parent or Guardian: _____ Date: _____ E-mail Address: _____

PLEASE CHECK YOUR SELECTION BELOW:	
COVERAGE PLANS	BASIC PLAN
24-Hour excluding High School Football (PK-12)	• $73.00
At School excluding Athletics/Activities/Football (PK-6)	• $15.00
At School (grades 7-12) excluding Senior High Interscholastic Athletics & Football	• $16.00
COMPANY USE ONLY: Check # _____ Amount Rec'd	**Enclose check for total payment payable to: Health Special Risk** TOTAL All Selections HERE: $ _____

Once completed, mail this form to:

Health Special Risk, Inc.
P.O. Box 674239
Dallas, TX 75267-4239

For more information or assistance regarding all Student Insurance, contact our Customer Service Department at **1-866-409-5733**

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***

Accident Coverage underwritten by: Starr Indemnity & Liability Company, 399 Park Avenue, 8th Floor, New York, NY 10022