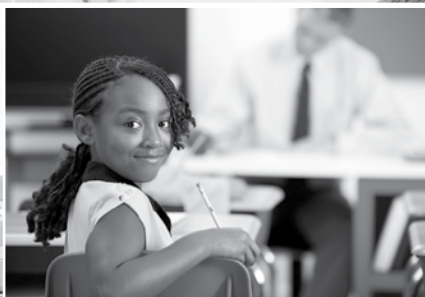


Voluntary Student Accident Insurance
[School Name- - - - -]
Variable field- - - - -]



PLAN ADMINISTRATOR



Health Special Risk, Inc.
HSR Plaza II
4100 Medical Pkwy.
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 Mutual of Omaha Insurance Company.

OFFERED THROUGH



Insurance for Students, Inc.
5295 Town Center Road, Suite 101
Boca Raton, Florida 33486

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

UNDERWRITTEN BY



Mutual of Omaha

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



2016-2017
MIAMI DADE COUNTY PUBLIC SCHOOLS
K-12 Voluntary Student Accident Insurance Coverage

Coverage underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

ELIGIBILITY:

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

COVERAGE OPTIONS

24-HOUR COVERAGE: Provides coverage for injuries incurred 24-Hours a day, 365 days a year, at home, at school and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities).

AT SCHOOL COVERAGE: Insurance coverage is provided: (a) on school premises during the hours and days when school is in session, (b) on school premises when school is not in session if participating in or attending any school sponsored event or activity; and (c) while attending or participating in school sponsored and supervised activities off school premises (i.e. day field trips).

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.

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.

ACCIDENTAL DEATH AND SPECIFIC LOSS: Benefits are paid for losses incurred within 180 days from the date of Injury. The following benefits (the largest applicable amount) are paid in addition to the medical benefit:

Table with 2 columns: Benefit Description and Amount. Rows include 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), and Loss of Thumb and Index Finger of the Same Hand (\$500.00).

DEFINITIONS

Allowable Expense means a Medical Expense otherwise payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us.

Injury means bodily harm which: (1) requires treatment by a Physician; (2) results in loss due to an Accident, independent of Sickness and all other causes; and (3) occurs within the Scope of Coverage.

Hospital means an institution which: (1) is operated pursuant to law; (2) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; (3) is under the supervision of a staff of Physicians; (4) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and (5) has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis. Hospital does not include: (1) a clinic or facility for: (a) convalescent, custodial, educational or nursing care; (b) the aged, drug addicts or alcoholics; (c) rehabilitation; or (2) a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) the services are rendered on an emergency basis; and (b) the individual has a legal liability to pay for the services given in the absence of insurance.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for a loss due to or expenses incurred for:

(1) intentionally self-inflicted injury, suicide while sane or insane; (2) voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician; (3) Injury caused by, attributable to, or resulting from the Insured's Intoxication; (4) Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (5) operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (6) operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred; (7) commitment of or an attempt to commit a felony, or engagement in an illegal activity; (8) participation in a riot or insurrection; (9) any Injury that results from fighting, brawling, assault or battery; (10) an act of declared or undeclared war; (11) active duty service in any Armed Forces; (12) operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the INSURED RISKS section of this policy; (13) mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment); (14) parachuting, except for self-preservation; (15) snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing; (16) participation in professional or amateur racing; (17) injuries associated with activities or travel outside the United States; (18) sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning; (19) dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth; (20) any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law; (21) charges which the Insured would not have to pay if the Insured did not have insurance; (22) a charge which is in excess of the Allowable Expense; (23) cosmetic surgery, except reconstructive surgery due to a covered Injury; (24) participation in semi-professional and professional sports, play or practice, or any related travel; (25) participation in practice or play of any sports activity, including travel to and from games and practice, unless specified in this policy; (26) assistant surgeon services, unless specified in this policy; (27) elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved; (28) Pre-existing Conditions; (29) any Heart or Circulatory Malfunction; (30) loss caused by or resulting from nuclear radiation or the release of nuclear energy; (31) services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan; (32) services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited; (33) travel in or upon: (a) a snowmobile; (b) any two or three wheeled motor vehicle; (c) any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated; (34) any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program); (35) treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

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 SR2014 FL LG. Exclusions and Limitations will apply. Should there be any discrepancy between the policy and this student accident information, policy provisions will prevail.

STUDENT ACCIDENT INSURANCE SCHEDULE OF BENEFITS

INPATIENT:	BASIC PLAN
Room & Board	\$1,000 aggregate maximum per day
Hospital Miscellaneous	100% of Allowable Expense
Registered Nurse	100% of Allowable Expense
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 Allowable Expense
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 Allowable Expense (treatment must be rendered within 72 hours from time of injury)
X-Ray Services (includes charges for reading)	\$75 maximum
Cat Scan	\$375 maximum
MRI	\$750 maximum
Laboratory	No Benefits
Injections	No Benefits
Prescription Drugs	No Benefits
Orthopedic Braces and Appliances	\$250 maximum
INPATIENT AND/OR OUTPATIENT:	
Surgeon's Fees	100% of Allowable Expense (specified surgery based on the Florida Workers' Compensation Schedule)
Anesthetist	100% of Allowable Expense
Assistant Surgeon	100% of Allowable Expense
Ambulance	\$250 maximum
Consultant	Paid under Physician's visit
Dental (injury to sound, natural teeth only)	Up to \$500 per tooth/\$1,000 maximum (includes orthodontia as a result of a covered injury)
Dental X-Rays	\$15 per tooth/\$40 full mouth
Replacement of Eyeglasses, Contact Lenses and Hearing Aids	100% of Allowable Expense (When broken as a result of a covered injury)
Hearing Aids	Paid under Orthopedic Braces and Appliances
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)
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 RATES
24-Hour excluding High School Football (PK-12)	\$79.00
At School excluding Athletics/Football (PK-6)	\$16.00
At School (grades 7-12) excluding Senior High Interscholastic Athletics & Football	\$18.00



**2016-2017
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)	<input type="checkbox"/> \$79.00
At School excluding Athletics/Activities/Football (PK-6)	<input type="checkbox"/> \$16.00
At School (grades 7-12) excluding Senior High Interscholastic Athletics & Football	<input type="checkbox"/> \$18.00
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: Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175