

STUDENT ACCIDENT INSURANCE

Wilson Sports Insurance Services, LLC

43 Crown Rd., Willow Park, TX 76087 Phone: 817-441-6487 Fax: 817-441-6483 <http://www.wilsonsportsins.com>

SRP - 1400 (HLA), HPP Brochure No.: CV0814-4 Underwritten by: Hartford Life and Accident Insurance Company Revised August 2015
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This is Limited Accident Only Coverage.

EXCLUSIONS: The Benefits under this policy are subject to the following exclusions. Other exclusions also apply. For a complete list of the exclusions, please refer to the insurance policy. The Policy does not cover loss resulting from or for: 1. intentionally self-inflicted injury, suicide, or attempted suicide, whether sane or insane; 2. war or act of war, whether declared or undeclared; 3. Injury sustained while in the armed forces (land, water or air) of any country or international authority; 4. Injury sustained while in or on, boarding or alighting from, being struck or run down by, any aircraft except as an airline passenger on an aircraft; (a) operated by a passenger airline on a regularly scheduled trip over its established route or that is chartered by that airline; or (b) any transport type aircraft operated by the Military Airlift Command (MAC) of the US or any national government recognized by the US; 5. dental work or treatment on natural teeth which is not necessary for the repair or relief of injury; 6. repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration; 7. repair or replacement of artificial limbs or orthopedic braces; 8. Injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits; 9. Injury sustained while the Insured Person is voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines or hallucinogens, unless the drug is taken as prescribed or administered by a licensed Physician; 10. Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;

11. Injury sustained as a result of the Insured Person's being legally intoxicated from the use of alcohol while operating a motor vehicle; 12. Expenses incurred for services, treatment, supplies or facilities rendered by: (a) the Policyholder's health service or infirmary; (b) any Physician or nurse employed or retained by the Policyholder; 13. Expenses covered under any automobile reparations insurance (no-fault) or automobile insurance medical payments benefit.

HOW TO FILE A CLAIM Proof of loss must be sent to us within 90 days after the date of the loss. If the claimant is not able to send proof within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated. Please submit claims under the student accident insurance policy to: Fringe Benefit Coordinators, PO Box 5249, Gainesville, FL 32627 A copy of the bills and expenses incurred should be attached to a claim form and forwarded promptly, when available.

VOLUNTARY STUDENT ACCIDENT INSURANCE PLAN 2016 - 2017 Up to the maximum benefit of the plan selected will be paid for the covered injuries (including heat stroke, heat exhaustion, or heat related injuries) sustained in any one accident which occurs on or after the effective date of coverage. The following treatment, care and services must occur within 26 weeks after the date of accident, and not exceed the specified amounts, provided that the first treatment is incurred within 90 days after the date of accident. Payment will be coordinated for expenses as EXCESS per accident for which any other collectible insurance is collectible, including HMO's, PPO's, Workers' Compensation and automobile No-fault insurance.

BENEFITS PROVIDED AND VOLUNTARY STUDENT ACCIDENT COVERAGE AMOUNTS Voluntary Student Accident Insurance Plan - Texas K-12 School Time - 24-Hour Coverage for Injuries due to Accident only. Voluntary plan. Medical benefits are paid for expenses which are incurred within 52 weeks from the date of the covered injury, provided that treatment is received within 26 weeks of injury. Accidental Death & Dismemberment losses must occur within 180 days after date of Accident causing such loss. Payment is made for Reasonable and Expenses if the treatment is determined by a Physician to be Medically Necessary and will be subject to all terms and conditions under the Policy. All benefits are paid on a per-injury basis.

Accident Medical Expense Benefit (school time, football & 24-hour) \$25,000 Deductible \$0 Motor Vehicle Injuries \$5,000 Death Benefit \$5,000 principal sum Dismemberment Benefit \$5,000 principal sum Physician's Office Visit Treatment (other than a Surgeon) \$10 per visit / \$100 max Surgeon Expenses: refer to attached Surgical Schedule for examples Paid in accordance w/surgical

(only one surgery covered per incision) 80 per-point value to \$800 max Anesthesiologist Expenses (only if Surgeon is paid) 25% of surgery benefit paid Assistant Surgeon (only if Surgeon is paid) 25% of surgery benefit paid Hospital-ICU Room & Board (both paid as Hospital Semi-Private room) \$200 per day Hospital Inpatient Miscellaneous Expense \$250 1st day / \$2,000 max

(including Radiology & Diagnostic imaging as provided below) \$100 per day thereafter Hospital Outpatient Emergency Room Physician \$30 max Outpatient Hospital Care & Service treatment at a hospital Emergency Room or \$60 max

Outpatient Dept, including lab, in addition to benefits for Physician's treatment & radiology & diagnostic imaging as provided.

Hospital Outpatient Surgical Facility (other than ER) \$500 max X-rays - Outpatient including interpretation \$60 max Diagnostic Imaging - Outpatient (CT/MRI, including interpretation) \$200 max Registered Nurse's Services (does not include Anesthesiology) \$100 max Dental Treatment (Injury to sound, natural teeth only) \$50 max per tooth Extended Dental Coverage (optional coverage-additional \$13) \$500 max per tooth Professional Ambulance-Ground Transport Only Usual & customary / \$80 max

(one trip per injury from Accident scene to hospital) Orthopedic Appliances/Durable Medical Equipment \$100 max

(when ordered by Attending Physician) Outpatient Prescription Drugs \$25 max Replacement of Eye Glasses, Contact Lenses & Hearing Aids \$50 max

only when medical treatment is also required for covered injury) Chiropractic Treatment by licensed physician or therapist for covered Losses only \$20 per visit / \$100 max

(Inpatient & Outpatient) Physical Therapy for covered Losses only (Inpatient & Outpatient) \$100 max Expanded Medical Benefit up to \$300 per injury Field Trip Benefit up to \$1,500 per injury

School Time Accident Coverage a) On the grounds of the school (including the parking lot) during normal school days. Extracurricular and Club Activities are included. b) Traveling at any time on a bus operated for the purpose of transporting Insured Persons for school sponsored activities. c) Participating in all school sponsored athletic/UII activities (excluding Football, Grades 7-12), including regularly scheduled practice sessions, games, tournaments, events located at other schools, and/or travel directly to & from athletic events. d) School sponsored field trips are covered for all Insured Persons.

OPTIONAL ADDITIONAL COVERAGES Optional Football coverage (Grades 7-12) Participating in school sponsored athletic/UII activities, including regularly scheduled practice sessions, games, tournaments, events located at other schools, and/or travel directly to and from athletic events. Optional 24-hour Accident Coverage Participating in around-the-clock, non-school related activities resulting in accidental injuries. Note: 24-hour accident coverage is not intended to provide benefits for Football injuries, grades 7-12. Optional Extended Dental Coverage Benefit By adding an additional \$13 premium to the \$45 base plan rate, dental benefits may be extended under the overall maximum benefit to provide payment of covered expenses to a maximum of \$500 per tooth. The additional benefit provides payment for the usual and customary expenses. EFFECTIVE & TERMINATION DATE Effective Date: Each person becomes an Insured Person on the date he or she meets the qualifications stated in the Schedule. For Voluntary Coverage, if an enrollment form and premium is received within 31 days of the policy effective date, coverage will be effective for the individual on the policy effective date. If an enrollment form is received greater than 31 days after the policy effective date, then individual coverage will begin on the date the Hartford receives both the enrollment form and premium for the individual. The Hartford will not refund premium on a pro-rata basis for premiums that are paid after 31 days past the policy effective date. Termination Date: Coverage of each Insured Person ceases on the first to occur of: (a) the date the Policy terminates; or (b) the date he or she ceases to qualify as an Insured Person. Termination shall be without prejudice to any claim for loss due to an accident that occurs before the termination date.

Please detach & return the form below:

STUDENT ACCIDENT VOLUNTARY INSURANCE ENROLLMENT FORM Coverage is underwritten by The Hartford -Fill Out Completely, Please Print Clearly & Check Coverages Below

School District _____
School Name _____
Student Full Name (First, MI, Last) _____
Street Address _____
City / State / Zip Code _____
Grade _____
Date of Birth _____
Signature (parent or guardian) _____
Date Signed _____
Email _____

PLEASE NOTE: Proof of enrollment will be provided after check or money order is received. The master policy will be on file with the School District. Please keep this brochure to refer to Benefits & Provisions when needed.

EASY ONE-TIME PAYMENT (No Cash. Only Check or Money Order)

- SCHOOL-TIME COVERAGE** _____ **\$45.00**
OPTIONAL FOOTBALL COVERAGE (Grades 7-12) _____ **\$235.00**
OPTIONAL 24-HOUR ACCIDENT COVERAGE _____ **\$130.00**
OPTIONAL EXTENDED DENTAL COVERAGE BENEFIT _____ **\$13.00**

(NO CASH. Check or Money Order made payable to Wilson Sports Insurance Services, LLC)