Voluntary
Student Accident Plan Premium Rates
Premium Rates for 2015/2016

This Policy Plan provides coverage up to $25,000 for each Injury and is designed to pay Covered Medical Expenses incurred as a result of accidental Injury. Certain specific benefits are limited. See Schedule of Benefits and Exclusions and Limitation pages for additional information.

Premium Rates include Extended Dental

24 Hour Coverage

Provides coverage for injuries sustained all year long; 24-hours a day until one year after the date the school year begins. Covers all interscholastic athletics except High School Football.

	LOW	HIGH
24 Hour All Year	$105	$154
24 Hour Summer Only	$36	$48

At School Coverage:

Provides coverage for injuries sustained at school or during school-sponsored activities until the end of the regular school term. Covers all interscholastic athletics except High School Football.

	LOW	HIGH
At School Coverage	$29	$37

High School Football Coverage:

Provides coverage for Injuries sustained while practicing or participating in High School Football.

	LOW	HIGH
Football	$171	$284
Spring Football	$74	$120

Voluntary Coverage – Low Option
Student Accident Plan Schedule of Benefits
2015/2016

The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that the treatment begins within 60 days from the date of the Injury, benefits will be payable for covered Medical Expenses incurred within one year from the date of the Injury up to the maximum benefit per service as scheduled below. Covered Expenses means the Medically Necessary and Reasonable Charges for services, supplies, and treatment provided or prescribed by a Physician for which an Insured Person is required to pay. Benefits are subject to all applicable conditions, exclusions and limitations and any deductible and coinsurance provisions shown. Benefits are limited to the amounts shown for specific services or supplies.

Maximum Benefit: $25,000 (For Each Injury) **Deductible: None**

Inpatient	
Room & Board:	$150 per day
Hospital Miscellaneous:	$600 per day
Registered Nurse:	75% of Reasonable Charges
Physician's Visits:	$40 first day/$25 each subsequent day
Outpatient	
Day Surgery Miscellaneous:	$1,000 maximum
Physician's Visits: ***(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)***	$40 first day/$25 each subsequent day
Physiotherapy: ***(Benefits are limited to one visit per day)***	$30 first day/$20 each subsequent day/5 days maximum
Emergency Room: ***(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)***	$150 maximum
X-Rays:	$200 maximum
CAT Scan/MRI:	$300 maximum
Laboratory:	$50 maximum
Prescription Drugs:	$75 maximum/30 day supply per prescription
Orthopedic Braces & Appliances:	$75 maximum
Inpatient and/or Outpatient	
Surgeon's Fees: ***(Limited to primary procedure per injury)***	$1,000 maximum
Anesthetist/Assistant Surgeon:	20% of surgery allowance
Ambulance:	$300 maximum
Consultant:	$200 maximum
Dental:	$10,000 maximum per injury

Expenses for the following are not covered:
Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

This is a brief illustration of coverage offered through the K12 Student Athletic and Accident Insurance. The Master Policy issued will be the contract and will govern and control the payment of benefits. The Policy is a non-renewable one year term policy. The policy contains an Excess Provision. No benefits are payable for expense incurred that is paid or payable by other valid and collectible insurance. The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 75th percentile of Ingenix schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

Voluntary Coverage – High Option
Student Accident Plan Schedule of Benefits
2015/2016

The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that the treatment begins within 60 days from the date of the Injury, benefits will be payable for covered Medical Expenses incurred within one year from the date of the Injury up to the maximum benefit per service as scheduled below. Covered Expenses means the Medically Necessary and Reasonable Charges for services, supplies, and treatment provided or prescribed by a Physician for which an Insured Person is required to pay. Benefits are subject to all applicable conditions, exclusions and limitations and any deductible and coinsurance provisions shown. Benefits are limited to the amounts shown for specific services or supplies.

Maximum Benefit: $25,000 (For Each Injury) **Deductible: None**

Inpatient	
Room & Board:	80% of Reasonable Charges
Hospital Miscellaneous:	$1,200 per day
Registered Nurse:	100% of Reasonable Charges
Physician's Visits:	$60 first day/$40 each subsequent day
Outpatient	
Day Surgery Miscellaneous:	$1,200 maximum
Physician's Visits:	$60 first day/$40 each subsequent day ***(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)***
Physiotherapy: ***(Benefits are limited to one visit per day)***	$60 first day/$40 each subsequent day/5 days maximum
Emergency Room: ***(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)***	$300 maximum
X-Rays:	$600 maximum
CAT Scan/MRI:	$600 maximum
Laboratory:	$300 maximum
Prescription Drugs:	$200 maximum/30 day supply per prescription
Orthopedic Braces & Appliances:	$140 maximum
Inpatient and/or Outpatient	
Surgeon's Fees: ***(Limited to primary procedure per injury)***	$1,200 maximum
Anesthetist/Assistant Surgeon:	25% of surgery allowance
Ambulance:	$800 maximum
Consultant:	$400 maximum
Dental:	$10,000 maximum per injury

Expenses for the following are not covered:
Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

This is a brief illustration of coverage offered through the K12 Student Athletic and Accident Insurance. The Master Policy issued will be the contract and will govern and control the payment of benefits. The Policy is a non-renewable one year term policy. The policy contains an Excess Provision. No benefits are payable for expense incurred that is paid or payable by other valid and collectible insurance. The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 75th percentile of Ingenix schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

Policy Exclusions and Limitations

Accidental Death & Dismemberment Benefits:

Loss of Life	$10,000
Loss of Both Hands, Both Feet, or Sight of Both Eyes	$10,000
Loss of One Hand and One Foot	$10,000
Loss of Either One Hand or One Foot and Sight of One Eye	$10,000
Loss of One Hand or One Foot or Sight of One Eye	$5,000

General Exclusions:

The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced.

We will not pay Benefits for:

1. An Injury or Loss that is:
   a. caused by war or acts of war, declared or undeclared, when serving in the military or an auxiliary unit thereto;
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to- automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.
5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders:

We will not pay Benefits for:

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law or similar law.
5. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
6. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
7. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
8. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
9. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
10. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
11. Expenses Incurred for supervision of an anesthetist.
12. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
13. Expenses Incurred for subsequent repairs and replacement of prosthetic devices and orthopedic braces and appliances.

Injury or Injuries

A bodily injury which is:

1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:

1. Malfunction must occur while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries or aggravation of such injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

K&K INSURANCE

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STUDENT ACCIDENT INSURANCE
ENROLLMENT FORM

A. General Information

Name of School/District:._____

School Mailing Address:_____

City:_____ State:_____,Zip:_____

Contact Name: Title:_____

Phone: Fax:_____

Email:_____

B. Voluntary Plans

Estimated annual school enrollment *(total number of students}:* _____

Grades *(mark one):* O PK-12 O Elementary School O Middle School O High School

Effective Date:_____ Date of first day of class for following school year:._____

C. Mandatory Plans *(Coverage selected by school/district)*

	Product Option	*Grades*	*Total# of Insured*	*Rate*	*Premium*
At-School Including Athletics & Activities					
At-School Excluding Athletics & Activities					
Athletics & Activities					
Field Trip					
School Band					
ROTC					
Other *{Please Specify)*					
Other *{Please Specify)*					
Other *{Please Specify)*					

D. Notes

I understand that the insurance company, in determining whether to provide insurance coverage, will rely on the information contained in this form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

I further acknowledge that I have reviewed all information provided with this enrollment form and understand the exclusions that apply, as well as the activities and operations for which coverage is not provided.

_____ _____
Signature of Official Authorized to Contract for School/District — Date Signed

_____ _____
Printed Name — Title

_____ _____
Agent Signature — Date Signed

_____ _____
Agent Printed Name — Agent Number