### 2016-2017 Student Accident Coverage

Serviced by: K&K Insurance Group, Inc.  Phone: 855-742-3135

**Remember to visit our website for faster enrollment:** www.studentinsurance-kk.com

Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.

**ACCIDENT ONLY COVERAGE:** The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatment by a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of Injury up to the Maximum Benefit per service as shown below.

**SCHEDULE OF BENEFITS:** Maximum Benefits Paid As Specified Below. Medically Necessary and Reasonable Charges are based on the 75th percentile.

<table>
<thead>
<tr>
<th></th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compare and Choose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit:</td>
<td>$25,000 (For Each Injury)</td>
<td>$25,000 (For Each Injury)</td>
</tr>
<tr>
<td>Deductible:</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Inpatient**

<table>
<thead>
<tr>
<th></th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board:</td>
<td>Up to $150 per day/</td>
<td>90% of Reasonable Charges/</td>
</tr>
<tr>
<td></td>
<td>Semi-private room rate</td>
<td>Semi-private room rate</td>
</tr>
<tr>
<td>Hospital Miscellaneous:</td>
<td>$600 maximum per day</td>
<td>$1,200 maximum per day</td>
</tr>
<tr>
<td>Registered Nurse:</td>
<td>75% of Reasonable Charges</td>
<td>100% of Reasonable Charges</td>
</tr>
<tr>
<td>Physician’s Visits:</td>
<td>$40 first day/$25 each subsequent day</td>
<td>$60 first day/$40 each subsequent day</td>
</tr>
</tbody>
</table>

**Outpatient**

<table>
<thead>
<tr>
<th></th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery Miscellaneous:</td>
<td>$1,000 maximum</td>
<td>$1,200 maximum</td>
</tr>
<tr>
<td>Physician’s Visits: (Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)</td>
<td>$40 first day/$25 each subsequent day</td>
<td>$60 first day/$40 each subsequent day</td>
</tr>
<tr>
<td>Outpatient Physical Therapy: (Benefits are limited to one visit per day)</td>
<td>$30 first day/$20 each subsequent day/ 5 days maximum</td>
<td>$60 first day/$40 each subsequent day/ 5 days maximum</td>
</tr>
<tr>
<td>Emergency Room Services: (Treatment must be rendered within 72 hours from the time of the injury)</td>
<td>$150 maximum</td>
<td>$300 maximum</td>
</tr>
<tr>
<td>X-Rays:</td>
<td>$200 maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>Diagnostic Imaging Services:</td>
<td>$300 maximum</td>
<td>$600 maximum</td>
</tr>
<tr>
<td>Laboratory:</td>
<td>$50 maximum</td>
<td>$300 maximum</td>
</tr>
<tr>
<td>Prescription Drugs:</td>
<td>$75 maximum</td>
<td>$200 maximum</td>
</tr>
<tr>
<td>Injections:</td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Orthopedic Braces &amp; Appliances:</td>
<td>$75 maximum</td>
<td>$140 maximum</td>
</tr>
</tbody>
</table>

**Inpatient and/or Outpatient**

<table>
<thead>
<tr>
<th></th>
<th>Low Option Accident Only</th>
<th>High Option Accident Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Fees: (Limited to primary procedure per injury)</td>
<td>$1,000 maximum</td>
<td>$1,200 maximum</td>
</tr>
<tr>
<td>Anesthetist:</td>
<td>20% of Surgery Allowance</td>
<td>25% of Surgery Allowance</td>
</tr>
<tr>
<td>Assistant Surgeon:</td>
<td>20% of Surgery Allowance</td>
<td>25% of Surgery Allowance</td>
</tr>
<tr>
<td>Ambulance:</td>
<td>$300 maximum</td>
<td>$800 maximum</td>
</tr>
<tr>
<td>Consultant:</td>
<td>$200 maximum</td>
<td>$400 maximum</td>
</tr>
<tr>
<td>Dental Treatment due to Injury to Teeth: (For Injury to sound, natural teeth only)</td>
<td>$10,000 maximum per policy term</td>
<td>$10,000 maximum per policy term</td>
</tr>
<tr>
<td>Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a Covered Injury:</td>
<td>100% of Reasonable Charges</td>
<td>100% of Reasonable Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment:</td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Maternity:</td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Complication of Pregnancy:</td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
</tbody>
</table>

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

This policy contains an excess provision. Benefits will not be paid under the Basic Accident Medical Expense for Covered Expenses to the extent that they are collectible under another Health Care Plan.

Details of these benefits may be found in the Master Policy on file at the School District. **NOTE:** This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control the payment of benefits.
Choose Your Coverage Plan:  One-Time Payment For Accident Coverage

PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW

CoverageEffective Date: A person’s coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.

Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

<table>
<thead>
<tr>
<th>Low Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>$105.00</td>
<td>$154.00</td>
</tr>
<tr>
<td>$36.00</td>
<td>$48.00</td>
</tr>
<tr>
<td>$29.00</td>
<td>$37.00</td>
</tr>
<tr>
<td>$71.00</td>
<td>$284.00</td>
</tr>
<tr>
<td>$200.00</td>
<td>$321.00</td>
</tr>
<tr>
<td>$276.00</td>
<td>$438.00</td>
</tr>
</tbody>
</table>

Facts about the Policy

1. WHO IS ELIGIBLE: students of the policyholder who make the required premium contribution for the coverage selected are eligible. Student status continues after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy on file with the school district is a non-renewable policy.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: A person’s coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.
6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.
7. CANCELLATION: Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
8. STUDENT TRANSFER: The policy continues to be in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.

Enroll online at: www.Studentinsurance-kk.com
or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to Nationwide Life Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child’s name on your check or money order.
4. Mail completed enrollment form with payment back to:
   K&K Insurance Group,
   P.O. Box 2338
   Fort Wayne, IN 46801-2338
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information.

Administered by:
K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338
Policy Exclusions and Limitations for Accident Only Coverages

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 any act of war, declared or
      undeclared, whether civil or international, or any
      actual armed conflict between organized forces
      of military nature (which does not include acts of
      terrorism);
   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.”;
   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. That part of medical expenses payable by any automobile
   insurance Policy without regard to fault.

5. Expenses incurred for any treatment that is considered
   to be experimental by the American Medical Association
   (AMA) or the American Dental Association (ADA).

6. 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.

7. 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.

8. Expenses incurred for personal comfort or convenience
   items including, but not limited to, Hospital telephone
   charges, television rentals, or guest meals.

9. Expenses incurred for or in connection with Custodial Care,
   unless otherwise specified in the Schedule of Benefits.

10. Expenses incurred for supervision of an anesthetist.

11. Expenses incurred for Durable Medical Equipment rental in
    excess of the purchase price.

12. Expenses incurred for subsequent repairs and replacement
    of prosthetic devices.

13. Expenses incurred for any condition covered by any
    Workers’ Compensation Act, Occupational Disease law or
    similar law.

Accident Only Definitions:

Injury 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 before age 65 while the Insured
   is taking part in a Covered Activity; and

2. The symptom(s) of such malfunction(s) is (are) first
   medically treated 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 infection, angina pectoris, coronary
   thrombosis, hypertension, heart attack, or a cerebral
   vascular incident.

Accidental Death & Specific Loss Benefits:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$10,000</td>
</tr>
<tr>
<td>Both arms or both legs</td>
<td>$10,000</td>
</tr>
<tr>
<td>Both hands and both feet</td>
<td>$10,000</td>
</tr>
<tr>
<td>One arm and one leg</td>
<td>$10,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$10,000</td>
</tr>
<tr>
<td>Either both hands or both feet</td>
<td>$10,000</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>$10,000</td>
</tr>
<tr>
<td>The sight of both eyes</td>
<td>$10,000</td>
</tr>
<tr>
<td>The sight of one eye and either one hand or one foot</td>
<td>$10,000</td>
</tr>
<tr>
<td>Either one arm or one leg</td>
<td>$7,500</td>
</tr>
<tr>
<td>Either one hand or one foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>Speech or hearing in both ears</td>
<td>$5,000</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>$5,000</td>
</tr>
<tr>
<td>Hearing in one ear</td>
<td>$2,500</td>
</tr>
<tr>
<td>Both the thumb and index finger of one hand</td>
<td>$2,500</td>
</tr>
</tbody>
</table>
### Enrollment Form (School Year 2016-2017)

Student’s Last Name: ____________________________________________
Student’s First Name: ____________________________________________
Student’s Middle Name: ____________________________________________ Date of Birth: ____________________________
Street Address: __________________________________________________
City: __________________________ State: __________ Zip: __________

Name of School District (required): ____________________________________________
Name of School: ________________________________________________________
Grade Level:  
- Pre-K/Headstart
- Kindergarten/Elementary
- Middle School
- High School/Above
Signature of Parent or Guardian: ____________________________________________
Date: __________________________ Email Address: ____________________________ Phone Number: __________________________

### Student Insurance Plan Options — Check Your Selection:

<table>
<thead>
<tr>
<th>Accident Only Coverage Plans</th>
<th>Low Option</th>
<th>High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-HOUR</td>
<td>$105.00</td>
<td>$154.00</td>
</tr>
<tr>
<td>24-HOUR Summer Only</td>
<td>$36.00</td>
<td>$48.00</td>
</tr>
<tr>
<td>AT-SCHOOL</td>
<td>$29.00</td>
<td>$37.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL COVERAGE Full Year</td>
<td>$171.00</td>
<td>$284.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL COVERAGE Spring Only</td>
<td>$74.00</td>
<td>$120.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and AT-SCHOOL</td>
<td>$200.00</td>
<td>$321.00</td>
</tr>
<tr>
<td>HIGH SCHOOL FOOTBALL and 24-HOUR</td>
<td>$276.00</td>
<td>$438.00</td>
</tr>
</tbody>
</table>

Enclose check for total payment payable to: Nationwide Life Insurance Company. Checks, money orders, or credit cards accepted. **DO NOT SEND CASH**

TOTAL ENCLOSED: ____________________________

Mail this completed form with payment back to: K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338

#### Complete this section only if you wish to pay with a Credit Card

Full name as it appears on card
First Name: __________________________ Mi: _______ Last Name: __________________________
Billing Address (if different than above)
Street # __________________________ Address __________________________ Apt #: __________
City: __________________________ State: __________ Zip: __________
Card Number: __________________________ Expiration Date: Month: _______ Year: _______
Cardholder signature: ____________________________________________

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)