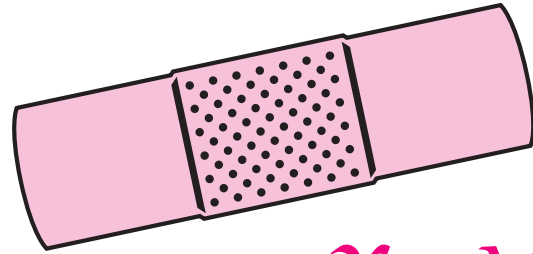


If your child has an injury. . . Will This Cover It?



You May Need **STUDENT INSURANCE** Your prescription for protection.

Fast, Accurate, Secure...Now Available:

ON-LINE ENROLLMENT

www.k12studentinsurance.com

For all customers, please browse through
www.familyhealthzone.com, a website with
interesting topics for all age groups

Underwritten by:

**The MEGA Life and
Health Insurance Company**

Serviced by:

Student Resources
A Division of The MEGA Life and
Health Insurance Company

- If you don't have other insurance, this student accident plan is vital.
- If you do have other insurance, this student accident plan can help fill those expensive "gaps" caused by deductibles and co-pays. This plan does not contain a deductible provision.
- Coverage can be purchased any time throughout the year. Remember to visit our website for faster enrollment.
- Checks, money orders, or credit cards accepted! **DO NOT SEND CASH.**



1. CHOOSE YOUR COVERAGE PLAN:

ONE TIME PAYMENT

24-HOUR ACCIDENT COVERAGE (Students & Employees)

	WITHOUT DENTAL	WITH EXTENDED DENTAL
Basic Option	\$90.00	\$99.00
Economy Option	\$62.00	\$71.00

- Around-the-clock/anywhere in the world; until school starts the following year
- Before, during and after school
- Weekends, vacation and all summer including summer school
- School sponsored and extracurricular sports **excluding high school football**

AT-SCHOOL ACCIDENT COVERAGE (Students & Employees)

	WITHOUT DENTAL	WITH EXTENDED DENTAL
Basic Option	\$27.00	\$36.00
Economy Option	\$16.00	\$25.00

- During the **regular** school term, on school premises while school is in session
- Direct and uninterrupted travel to and from home and scheduled classes
- School sponsored and supervised sports **excluding high school football**
- Travel to and from school sponsored and supervised sports while in a school furnished vehicle

EXTENDED DENTAL COVERAGE (Accident Only)

- Supplemental coverage extended to students with At-School, 24-Hour or Football Coverage - limited to Insured's policy effective dates
- Usual and customary expenses for examinations, x-rays, endodontics and oral surgery to a maximum of \$10,000
- Dental expenses toward cost of bridge, denture or replacement in kind of previous dental repairs with a maximum limit of \$250
- Extended dental coverage is excess to all other valid and collectible insurance - All other policy provisions, including policy exclusions and limitations, will apply

FOOTBALL COVERAGE

	WITHOUT DENTAL	WITH EXTENDED DENTAL
Basic Option	\$106.00	\$115.00
Economy Option	\$72.00	\$81.00

- An additional premium is required for high school interscholastic football
- Any 9th grade student that plays with the senior high team must purchase senior high football coverage
- Consult your Athletic Department for benefits, application and enrollment instructions

For INJURY AND SICKNESS coverage information and/or enrollment (ages 5-18) visit our website.

2. REVIEW YOUR BENEFITS:

MAXIMUM BENEFITS PAID AS SPECIFIED BELOW

The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit for each Injury. Provided that treatment by a qualified, licensed Physician begins within 30 days from the date of accident, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date of accident up to the Maximum Benefit per service as shown below. Policy benefits are not payable for any expenses incurred which are paid or payable by other valid and collectible insurance. Any supply or service not specifically listed is not covered. Usual and Customary Charges are based on the 75th percentile.

COMPARE AND CHOOSE	BASIC OPTION	ECONOMY OPTION
MAXIMUM BENEFIT	\$25,000 (For Each Injury)	\$25,000 (For Each Injury)
Deductible	\$0	\$0
INPATIENT		
Room & Board	Semi-private room rate / \$200 per day	\$400 first day / \$300 each subsequent day
Hospital Miscellaneous	80% of Usual & Customary Charges	Included in Room & Board
Intensive Care	\$400 per day	\$400 per day
Registered Nurse	100% Usual & Customary Charges	100% of Usual & Customary Charges
Physician's Visit	\$25 first day / \$15 each subsequent day <i>(Benefits are limited to one visit per day)</i>	\$20 first day / \$15 each subsequent day <i>(Benefits are limited to one visit per day)</i>
OUTPATIENT		
Day Surgery Miscellaneous	80% of Usual & Customary Charges <i>(Usual & Customary Charges are based on the Outpatient Surgical Facility Charge Index.)</i>	\$400 maximum
Physician's Visits	\$25 first day / \$15 each subsequent day <i>(Benefits are limited to one visit per day)</i>	\$20 first day / \$15 each subsequent day <i>(Benefits are limited to one visit per day)</i>
Physiotherapy	\$25 first day / \$15 each subsequent day / 10 days maximum <i>(Benefits are limited to one visit per day)</i>	\$20 first day / \$15 each subsequent day / 10 days maximum <i>(Benefits are limited to one visit per day)</i>
Medical Emergency	\$100 maximum <i>Treatment must be rendered within 72 hours from the time of the injury.</i>	\$75 maximum
X-Rays	\$450 maximum	\$400 maximum
Laboratory	100% of Usual & Customary Charges	100% of Usual & Customary Charges
Prescription Drugs	\$35 maximum	\$25 maximum
Orthopedic Braces & Appliances	\$100 maximum	\$100 maximum
INPATIENT AND/OR OUTPATIENT		
Surgery	80% of Usual & Customary Charges	70% of Usual & Customary Charges
Anesthetist/Assistant Surgeon	25% of amount paid for surgery	25% of amount paid for surgery
Ambulance	100% of Usual & Customary Charges <i>Ground Transportation to the nearest treatment facility. Air Ambulance is limited to \$500</i>	100% of Usual & Customary Charges
Dental	\$200 per tooth <i>(Benefits are paid on Injury to sound, natural teeth only.)</i>	\$200 per tooth
Other Special Coverages	\$150 maximum <i>This Benefit is for the Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a covered injury.</i>	\$100 maximum
Other	Applies to All of the Above <i>The maximum amount payable for an injury involving Senior High Football is \$25,000 for each Injury. For all other injuries, the maximum is \$100,000 for each Injury.</i>	Applies to All of the Above

ADDITIONAL BENEFITS: As mandated by Maryland Insurance Laws, benefits will be provided for Home Health Care and Hospice Care. The Master Policy Available at the school outlines all details and limitations of these benefits.

NOTE: This is an illustration and not a contract. A Master Policy has been filed with your District.

NOTE: Injury means bodily injury which is 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; and 4) sustained while the Covered Person is covered under the Policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these Injuries will be considered one Injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

STUDENT INSURANCE ID CARD



Student's Name _____
 If premium has been paid, the student whose name appears above has been insured under an accident only Policy issued to:
School District: _____
Coverage: 24-HOUR AT-SCHOOL
 EXTENDED DENTAL FOOTBALL
 Paid by Check # _____ Amount Paid: _____ Date Paid: _____
Claims Questions:
STUDENT INSURANCE, A Division of UICI
 P.O. Box 809066 • Dallas, TX 75380-9066 • 800-767-0700

3. CHOOSE HOW TO ENROLL:

ON-LINE @ www.k12studentinsurance.com
for fast, easy enrollment or:

- Complete and detach the enrollment form.
- Make check or money order payable to Student Insurance. **Do not send cash. The Company is not responsible for cash payments.** \$50 minimum requirement for credit card payments.
- Write your child's name on your check or money order.
- Insert check or money order in the attached envelope.
- Mail envelope to Student Insurance.
- Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
- Keep this brochure for future reference. Individual policies will not be sent to you.

Complete this section only if you wish to pay with MASTERCARD/VISA

Card Number

Exp. Date
Month Year

Print Name of Cardholder

X _____
Signature

Date:
MM DD YY

Total Charge: \$ _____
(Visa/MasterCard Payment available if total charge is over \$50.00)

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. You may obtain a detailed copy of our privacy practices through your school, by calling us toll-free at (800) 767-0700 or by visiting us at www.k12studentinsurance.com.

ENROLL ON-LINE FOR QUICKER SERVICE or Complete and Mail

Student Accident Insurance — Check ✓ Your Selection:

COVERAGE PLANS	Basic Option	Economy Option
24-HOUR with Extended Dental	\$99.00 <input type="checkbox"/>	\$71.00 <input type="checkbox"/>
24-HOUR without Dental	\$90.00 <input type="checkbox"/>	\$62.00 <input type="checkbox"/>
AT-SCHOOL with Extended Dental	\$36.00 <input type="checkbox"/>	\$25.00 <input type="checkbox"/>
AT-SCHOOL without Dental	\$27.00 <input type="checkbox"/>	\$16.00 <input type="checkbox"/>
Sr. HIGH FOOTBALL - with Extended Dental - without Dental	\$115.00 <input type="checkbox"/> \$106.00 <input type="checkbox"/>	\$81.00 <input type="checkbox"/> \$72.00 <input type="checkbox"/>
COMPANY USE ONLY Check No. _____ Amount Received _____ Date Received _____	Enclose check for total payment payable to: Student Insurance TOTAL ENCLOSED: \$ _____	

Enrollment Form

Underwritten by The MEGA Life and Health Insurance Company (PLEASE PRINT)

Student's Last Name

Student's First Name Middle Initial

Social Security #

DOB - - Grade

Phone - - -

Address _____

City _____ State _____ Zip _____

Name of School District _____ (Required to Process)

Name of Campus _____

X _____ Date _____
Signature of Parent or Guardian

Company does not issue refunds nor accepts responsibility for cash payments. (Return of check by bank for any reason, will invalidate insurance.)

ACCIDENTAL DEATH AND DISMEMBERMENT

One amount, the greatest, may be payable at the Insured's option within **180 days** from the date of accident in lieu of other benefits under the Policy.

Accidental Death\$5,000.00

Accidental Loss of:

Both Hands, Both Feet, or Sight of Both Eyes\$20,000.00

One Hand and One Foot\$20,000.00

Either One Hand or One Foot and Sight of One Eye\$20,000.00

Either One Hand or One Foot, or Sight of One Eye\$10,000.00

Entire Thumb and Index Finger of Either Hand\$500.00

ADDITIONAL FACTS ABOUT THE POLICY

1. **STUDENT TRANSFER:** The policy continues in force anywhere in the world if the Insured should relocate prior to the expiration of coverage.
2. **CANCELLATION:** Coverage under the Policy is non-cancellable, 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 an Insured enters the Military Service.
3. **INITIAL ENROLLMENT:** Coverage is effective the date the correct application and premium are received by the Company.
4. **LATE ENROLLMENT:** There is no premium reduction for any individual who enrolls late in the year.
5. **STUDENT HEALTH PLAN:** Coverage terminates on the earliest of: 1) the date the plan is terminated by the policyholder or, 2) the last day of the month for which the appropriate premium has been paid.
6. **Your cancelled check, credit card billing, or money order stub is your only receipt and notification of coverage.**

EXCESS PROVISION

If an Injury to the Insured results in His incurring Covered Medical Expenses for any of the services specified in the SCHEDULE OF BENEFITS, We will pay the Covered Medical Expenses incurred, subject to the Deductible Amount and Coinsurance Percentage (if any), that are in excess of Covered Medical Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The insured must be under the care of a Physician when the Covered Medical Expenses are incurred. The Covered Medical Expense must be incurred:

- solely for treatment of a covered Injury; and
- while the person is insured; or
- during the Benefit Period stated in the Schedule of Benefits.

The first expense must be incurred within thirty (30) days after the date of Injury.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with its policy provisions or requirements.

The total of all medical benefits payable under the policy is as shown in the Schedule of Benefits and is subject to the specific maximums shown in the Schedule of Benefits.

POLICY EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for loss due to:

1. Intentionally self-inflicted Injury, suicide while sane or insane or any attempt thereat;
2. Committing or attempting to commit a felony (only applies to the Accidental Death, Dismemberment, and Loss of Sight Benefit);
3. Participation in a riot or insurrection;
4. An act of declared or undeclared war;
5. Nuclear reactions or radiation contamination only to the extent of accidental contamination, release or exposure and not as a result of any act of terrorism;
6. Active duty service in any Armed Forces of any country and, in such event, the pro-rata unearned premium will be returned upon proof of service. This does not include Reserve or National Guard active duty or training unless it extends beyond 31 days;
7. 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;
8. Cysts or skin lesions such as blisters or boils, hernia, regardless of how caused;
9. Flight in an Aircraft, except as a fare-paying passenger;
10. Snow skiing; scuba diving; bob-sledding; bungee jumping; ballooning; sky diving; hang-gliding; glider flying; sail planing or parasailing;
11. Working on or around any motorcycle or recreational vehicle;
12. Travel in or upon: snowmobile; jet ski or ski cycle; any two or three wheeled motor vehicle; any four wheeled all terrain vehicle (ATV); any off-road motorized vehicle not requiring licensing as a motor vehicle;
13. Any loss for which benefits are paid under state or federal worker's compensation, employers liability, or occupational disease law;
14. For Accidental Death and Dismemberment benefit only, loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any narcotic, or any drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Insured's Physician;
15. Practice or play in any senior high interscholastic football; except where specific additional premium is paid;
16. Services or treatment rendered by a physician, nurse or any other person who is employed or retained by the Policyholder; or who is the insured or a member of his immediate family.

HOW TO FILE A CLAIM

NOTE: Medical treatment must be received from a qualified, licensed Physician within **30 days** from the date of accident.

1. Obtain a claim form quickly from our website, from your school office, or call Student Insurance (800-767-0700). Answer all questions in detail and include signatures to avoid claim from being returned for incomplete info.
2. Attach all bills to the completed form and mail to the insurance company within 90 days of the accident.
3. Any bills not filed with the claim form should be sent to the company identified with the student's name, school district, and date of accident. Bills that cannot be attached to the initial form must be submitted within 90 days of the date of service.
4. If you have other insurance, file simultaneous claims with your other insurance carrier and Student Insurance, a Division of UICI, to avoid a delay in benefit payments.

Administered by:

STUDENT INSURANCE

A DIVISION OF UICI

P.O. Box 809066

Dallas, TX 75380-9066

800-767-0700

469-229-6700

website: www.k12studentinsurance.com