Kenton County School District | *It's about ALL kids.*

Issue Paper

DATE:
August 9, 2024

AGENDA ITEM (ACTION ITEM):
Consider/Approve Renew KCSD participation in the Voluntary Student Accident Insurance program offered by K&K Insurance.

APPLICABLE BOARD POLICY:
09.312 Insurance (Athletics and Marching Band)

HISTORY/BACKGROUND:
K&K Insurance is a voluntary option for families of students involved in school athletic or marching band programs. All students participating in interscholastic athletics or marching band must present evidence of accident insurance coverage. The coverage provided through this voluntary option meets the established criteria for participation.

FISCAL/BUDGETARY IMPACT:
There is no financial obligation to KCSD. All costs associated with the voluntary enrollment is the responsibility of the participating individual.

RECOMMENDATION:
Approval Renew KCSD participation in the Voluntary Student Accident Insurance programed by K&K Insurance.

CONTACT PERSON:
Matt Wilhoite

Principal/Administrator	*District Administrator*	*Superintendent*

Use this form to submit your request to the Superintendent for items to be added to the Board Meeting Agenda.
Principal –complete, print, sign and send to your Director. Director –if approved, sign and put in the Superintendent's mailbox.

K&K INSURANCE
1712 Magnavox Way P.O. Box 2338
Fort Wayne, Indiana 46801
ph (855) 742-3135
www.studentinsurance-kk.com
email: info@studentinsurance-kk.com
CA License #0334819

WEB ENROLLMENT FLYER REQUEST FORM

Name of District:_____

IMPORTANT FOR SUPPLIES: An initial supply of web enrollment flyers will be shipped to the district office or one central location.

Supplies

❑ Web Only Enrollment

Shipping

Ship flyers to: ❑ District Office

Address: _____
Must be street address, not a PO box number.

City:_____ State:_____ Zip:_____

Attention:_____ Title:_____

Date flyers needed:_____

Do you want your flyers separated by campus?

❑ No Please indicate quantity of flyers needed:_____

❑ Yes Please indicate quantity of flyers below.

Do you want a pdf file of the brochure emailed to you to post on your school website?

❑ Yes Please provide email address:_____

❑ No

Campus Locations

Please provide a list of campus locations so all locations will be listed on the website for online enrollment. You may attach a listing of all campuses or fill in below. If flyers are to be separated by campus, indicate number of flyers needed next to each campus location.

Campus Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Attention:_____ Title:_____
Number of Flyers ☐

Campus Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Attention:_____ Title:_____
Number of Flyers ☐

Campus Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Attention:_____ Title:_____
Number of Flyers ☐

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Campus Name:____

Address: ____

City:____________________ State:____________ Zip:____________

Attention:____________________ Title:____________________

Number of Flyers [ ]

Coverage Plans and Rates

24-Hour Accident Around-the-clock. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football	Low Option High Option	$112.00 $165.00
24-Hour Accident (Summer Only Coverage) Summer begins on the first day after the school year ends. Summer ends the first day of the next school year.	Low Option High Option	$39.00 $51.00
At-School Accident 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 activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.	Low Option High Option	$30.00 $38.00
Extended Dental (Accident Only) Supplemental coverage extended to students with At-School, 24-Hour or Football Coverage – Limited to Covered Person's policy effective dates and accident only coverage option selected. Replaces standard dental coverage with coverage of 80% of Reasonable Charges to a maximum limit of $10,000 per policy term.		
High School Football Play or practice of regularly scheduled football.	Low Option High Option	$176.00 $293.00
High School Football (Spring Only) For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.	Low Option High Option	$76.00 $124.00

Schedule Of Benefits

Accident Medical Benefit

Scope of Coverage Applicable to Accident Medical Benefits

Any benefit limits and benefit percentages apply, unless otherwise specified, on a per Insured Person – per Covered Loss basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

Full Excess Medical Expense

Total Maximum for all Accident Medical Benefits	$25,000
First Covered Expenses must be incurred within	60 days after the Covered Accident
Benefit Period	52 weeks from the date of the Covered Accident
Deductible	$0
Deductible applies to	each Covered Accident
Deductible must be satisfied within	52 weeks from the date of the Covered Accident

Low Option

Inpatient Hospital Services

Room and Board Expenses	
Semi-Private Room	Up to $150 per day
Miscellaneous Expenses	$600 maximum per day
Physician's Visits (limited to one visit per day)	$40 first day/$25 each subsequent day
Ambulatory Medical Center	$1,000 maximum
Emergency Room Treatment (treatment must be rendered within 72 hours from the time of the injury)	$150 maximum
Surgery	$1,000 maximum

*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.

Assistant Surgeon	100% of Usual and Customary Charges

*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.

Anesthesia and its Administration	100% of Usual and Customary Charges

*Allowance is calculated: 20% of the surgical maximum for the surgery performed as indicated above.

Outpatient Physician Visits (limited to one visit per day)	$40 first day/$25 each subsequent day

Outpatient X-ray	$200 maximum
Outpatient Diagnostic Imaging Services	$300 maximum
Outpatient Laboratory	$50 maximum
Outpatient Physiotherapy (limited to one visit per day) (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	$30 first day/$20 each subsequent day, 5 day maximum
Ambulance Services (Air and Ground)	$300 maximum
Medical Equipment Rental (Includes Orthopedic devices)	$75 maximum
Dental Services	$10,000 maximum per policy term
Prescription Drugs	$75 maximum
Consultant	$200 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids	100% of Usual and Customary Charges

High Option

Inpatient Hospital Services	
Room and Board Expenses	
Semi-Private Room	80% of Usual and Customary Charges
Miscellaneous Expenses	$1,200 maximum per day
Physician's Visits (limited to one visit per day)	$60 first day/$40 each subsequent day
Ambulatory Medical Center	$1,200 maximum
Emergency Room Treatment (treatment must be rendered within 72 hours from the time of the injury)	$300 maximum
Surgery	$1,200 maximum

*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.

Assistant Surgeon	100% of Usual and Customary Charges

*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.

Anesthesia and its Administration	100% of Usual and Customary Charges

*Allowance is calculated: 25% of the surgical maximum for the surgery performed as indicated above.

Outpatient Physician Visits (limited to one visit per day)	$60 first day/$40 each subsequent day
Outpatient X-ray	$600 maximum
Outpatient Diagnostic Imaging Services	$600 maximum
Outpatient Laboratory	$300 maximum
Outpatient Physiotherapy (limited to one visit per day) (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)	$60 first day/$40 each subsequent day, 5 day maximum

Ambulance Services (Air and Ground)	$800 maximum
Medical Equipment Rental (Includes Orthopedic devices)	$140 maximum
Dental Services	$10,000 maximum per policy term
Prescription Drugs	$200 maximum
Consultant	$400 maximum
Replacement of Eye Glasses, Contact Lenses or Hearing Aids	100% of Usual and Customary Charges

Accidental Death and Dismemberment Benefits

Covered Loss must occur within 365 days of the Covered Accident. Not more than the Aggregate Limit of $500,000 will be paid for all Covered Losses, Covered Accidents and Covered Injuries suffered by all Insured Persons as the result of any one Covered Accident that occurs under one of the Conditions of Coverage. This Aggregate Limit is payable only once, should more than one Condition of Coverage apply. We will pay the greater amount. If this amount does not allow all Insured Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Insured Person's loss to the total of all losses, multiplied by the Aggregate Limit.

COVERED LOSS	BENEFIT AMOUNT
Loss of Life	$10,000
Loss of Two or More Hands or Feet	$10,000
Loss of Sight of Both Eyes	$10,000
Loss of Speech and Hearing (in Both Ears)	$10,000
Loss of One Hand or Foot and Sight in One Eye	$10,000
Loss of One Hand or Foot	$5,000
Loss of Sight in One Eye	$5,000
Loss of Speech	$5,000
Loss of Hearing (in Both Ears)	$5,000
Loss of Hearing in One Ear	$2,500
Loss of Thumb and Index Finger of the same Hand	$2,500
Exposure and Disappearance	Included

Exclusions

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. injuries compensable under Workers' Compensation law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. 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 moutain climbing;
15. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
16. benefits will not be paid for services or treatment rendered by any person who is:
    a. employed or retained by the Policyholder;
    b. living in the Insured Person's household;

c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or
d. the Insured Person.

EXCLUDED EXPENSES

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
5. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
6. repair or replacement of existing artificial limbs, eyes and larynx;
7. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician.

In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the *Schedule of Benefits*.

Other Exclusions that apply to this Benefit are in the Common Exclusions Section.