Up To $25,000 Voluntary Student Accident Medical Insurance Protection

Sponsored by the
Maine School Management Association

MSMA
MAINE SCHOOL MANAGEMENT ASSOCIATION

2020-2021

Administered by:
Alive Risk
(888) 533-7654

Underwritten by:
AXIS Insurance Company
Chicago, IL

Disclosure: US insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

24 HOUR ACCIDENT COVERAGE

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $50.00

SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and while under the supervision of school employees. Travel is limited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. . . . $ 11.00
Football - Grade 9. . . . . $150.00
Football - Grades 10-12. . . . . $250.00

CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or claims administrator, MCA Administrators Inc. at 800-427-9308. You will receive a claim form which must be filed with the Company within 90 days after the accident. Covered Excess Expenses incurred within one year from the accident will be considered. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

Direct All Questions To: ALIVE RISK (888) 533-7654

Optional $50,000 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means Replacement of caps, crowns, dentures, and orthodontic appliances, (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x- ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the Usual & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104- week period immediately following the date of Covered Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. If the Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel. $8.00

This coverage **cannot** be purchased without School Time or 24 Hour coverage.

Accidental Death & Dismemberment

Covered Loss must occur within 180 days of the Covered Accident. Loss of Life: $5,000. Loss of Two or More Hands or Feet: $20,000. Loss of Sight of Both Eyes: $20,000. Loss of One Hand or Foot and Sight in One Eye: $20,000. Loss of One Hand or Foot: $10,000. Loss of Sight in One Eye: $10,000. Loss of Thumb and Index Finger of the same Hand: $10,000. Loss of all Four Fingers of the Same Hand: $5,000.

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of a Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). If the Insured Person sustains more than one Covered Loss as a result of the same Covered Accident, the Company will pay the Benefit Amount for the Covered Loss for which the largest benefit is payable.

Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics / activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF $25,000 MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 52 weeks from the date of the Injury.

MAXIMUM BENEFITS Hospital Services:
Daily Room& Board (Semi-private) . Avg. Semi- Private Rate Up to $500/day
Intensive Care Room & Board . . . . . $750/Day not to exceed 7 days

Miscellaneous Services:
During Hospital Confinement or when surgery is performed 75% of Usual & Customary to $10,000

Emergency Room outpatient:
when Hospital Confinement
is not required . . . . . …… . $250.00

Doctor's Services:
Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition,
having a conversion factor of . . ……$140.00 unit value
Maximum $10,000
Anesthesia: (including administration)
and assistant surgeon: % of surgical allowance 30%

Doctor visits other than for physiotherapy or similar treatment when no surgery
benefitis paid . . . . . …… . . . ……Usual & Customary

Consultants (when required by attending physician for confirmation or determining a diagnosis, but
not for treatment) and second opinion: . …… . . $100.00

Laboratory & X-Ray Services:

Other than Dental and including fee for interpretation and/or reading of X-Ray
X-ray when not Hospital Confined X-Ray $500.00
Lab $500.00
MRI's, CAT Scans, Laser Treatments or similar procedures, including fee for interpretation and/or reading $500.00

Additional Services:
Physiotherapy or similar treatment:
In-Hospital $500.00
Out of Hospital. $500.00
Chiropractic Services (in or out of hospital) . . . …… ……$100.00
Registered Nurse (in or out of hospital……Usual &Customary
Ambulance to initial treatment facility……Usual &Customary

Orthopedic Appliances:
In-hospital $500.00
Out of hospital $500.00
Outpatient drugs & medication Administered
by a Doctor . . . . . ……. . .Usual & Customary

Eyeglasses, contact lenses and hearing aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting
from a covered Injury. . . . ……$300.00

Dental Services:
For treatment, repair or replacement of injured natural teeth, includes initial braces when required for treatment of a covered Injury, as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for
gingivitis resulting from trauma . . . . …… . . . . $400 /tooth
Maximum: $12,800

FULL EXCESS COVERAGE
Benefits are payable for Medically Necessary Covered Expenses that are in excess of amounts payable under any Other Health Care Plan and are subject to the applicable Total Maximum for all Accident Medical Benefits. If the Insured is not covered by any Other Health Care Plan providing Accident Medical Benefits, the excess provision shall not apply, and benefits are payable to the Total Maximum for all Accident Medical Benefits as shown in your Master Insurance Application.

EXCLUSIONS AND LIMITATIONS
Exclusions: The policy does not cover any loss incurred as a result of:

Limitation for Motor Vehicle Accidents
Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Limit shown in the *Schedule of Benefits*.

EXCLUDED EXPENSES

For the purposes of this Accident Medical Benefit, the following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault.
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury.
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses;
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
5. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).
6. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).

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

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

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. Illness or medical condition arising out of, suicide, or any attempt while sane or insane;
2. Death, injury incurred, or disease contracted, to which acontributing cause was the Insured Person's commission or attempt to commit a felony or which occurs while the Insured Person is engaged in an illegal occupation;
3. Illness, treatment or medical condition arising out of the commission of or active participation in a riot or insurrection;
4. Illness, treatment or medical condition arising out of the 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. parachuting;
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. Death, injury incurred, or disease contracted while the Insured Person is intoxicated or under the influence of any narcotic, or hallucinogenic drug, unless prescribed or taken under the direction of a Physician;
9. injuries compensable under Workers' Compensation law or any similar law;
10. 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.

Disclosure: US insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. This insurance provided limited benefits. Limited benefits are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, this insurance does not coordinate with any other insurance plans. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

To File A Claim:

1. To download a claim form, go to: www.aliverisk.com
2. Fill out all necessary information
3. Be sure to sign and date the bottom
4. Enclose itemized bills, paid receipts and/or other insurance explanation of benefits.
5. Send claim forms, itemized bills and receipts to:

MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308

Proof of Loss is required within 90 days from the date of the Accident. You have ONE year from the time Proof of Loss would have been required to file a claim. Claims submitted past this period will not be considered for payment under the policy.

ENROLLMENT FORM CHECKLIST

Did You:

- Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED) Check the appropriate box(s) for the coverage you have selected.
- Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of
- payment) along with the completed enrollment form in an envelope.

For questions, inquiries, and information contact:

ALIVE RISK (888) 533-7654

DO NOT SEND CASH
EnrollmentForm

Please Print **2020-2021**

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOME ADDRESS

APT# CITY ST ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOL NAME

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF PARENT OR GUARDIAN DATE

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

School Year Rate – 2020-2021 CHECK YOUR SELECTION

Coverage Plans	Premiums
24-Hour – Including Extended Dental	☐ $58.00
24 Hour Only	☐ $50.00
School Time Only – Including Extended Dental	☐ $19.00
School Time Only	☐ $11.00
Football - Grade 9	☐ $150.00
Football - Grades 10-12	☐ $250.00

Make checks payable to:
Alive Risk

How to Enroll

1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to Alive Risk shown for the correct amount.
3. Mail envelope to: A&H Lockbox - P.O. Box 45731 - Baltimore, MD 21297.
   Your cancelled check or money order stub will be your receipt and confirmation of payment.
   (Please write the student's name and school name on your check.)