



ACE USA  
 ACE American Insurance Company  
 1601 Chestnut Street  
 Philadelphia, PA 19103

Boy Scouts of America Council Accident & Sickness Plan  
 Gulf Ridge Council # 86

Effective Date: 02/01/09      Expiration Date: 02/01/10  
 Premium Amount: \$ ~~1,500.00~~      Premium Paid: \$ ~~3,500.00~~  
 Date Paid: 02/23/09      Balance: \$ ~~5,000.00~~

Policy Number PTP N00327402

**Description of Coverage**

**Eligibility:** All persons officially registered with the Boy Scouts of America (BSA), according to the following classifications:  
 Class I - All Youth; Learning for Life Explorer; Seasonal Volunteer Non-Paid Staff; and Non-Scouts, Non-Scouters and Guests, but only while attending scheduled activities for the purpose of becoming registered Leaders and Scouts.  
 Class II - All Adult Volunteer Leaders, including Den Aides and Chiefs who are 21 years of age or older (18 years of age or older if an Assistant Scoutmaster, Assistant Den Leader, Assistant Cub Master, or Assistant Webelo Den Leader).  
 Class III - All Learning for Life Non-Explorer Participants.  
 A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class.

**Period of Coverage:** You will be insured on the Effective Date shown above, provided the premium payment is received by the administrator, Health Special Risk, Inc. Your coverage will end on the earlier of: 1) the Termination Date shown above; or 2) the period ends for which premium is paid.

**Definitions:** **Accident:** means a sudden, unexpected and unintended event. **Covered Expenses:** means expenses actually incurred by or on behalf of an Insured for treatment, services and supplies covered by the Policy. Coverage must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. **Injury:** or injuries, for which benefits are provided, means accidental bodily injuries sustained by the Insured which are the direct cause, independent of disease, bodily infirmity or any other cause, of the loss from a covered Accident and occur while the insurance is in force for the Insured. **Medically Necessary:** means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Insured's condition; and 4) consistent at the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. **Purchasing or renting:** 1) air conditioners; 2) air purifiers; 3) motorized transportation equipment; 4) escalators or elevators in private homes; 5) eye glass frames or lenses; 6) hearing aids; 7) swimming pools or supplies for them; and 8) general exercise equipment are not Medically Necessary. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at our discretion, consider the cost of the alternative to be the Covered Expense. **Sickness:** means an illness, disease or condition of the Insured that causes a loss for which an Insured incurs medical expenses while coverage is in effect. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness. **Usual and Customary Charges:** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. **You or Your:** means the sponsoring BSA Council insured under the Policy.

**Covered Activities:** The Insured will be covered while: 1) participating in an official Scouting or Learning for Life activity. Seasonal camp staff persons are also covered during their off-duty hours; and 2) traveling to and from an official Scouting or Learning for Life activity. The covered Accident or Sickness must take place: 1) on the premises of the Policyholder during normal hours of operation; or 2) on the premises of the Policyholder during other periods if attending or participating in a Covered Activity; or 3) away from the premises of the Policyholder while attending or participating in a Covered Activity at its scheduled site. The Covered Activity includes travel without deviation or interruption between home and the site of the Covered Activity. Travel time includes the time: 1) to or from home and the premises of the Covered Activity; 2) before the appointed time; and 3) after the Covered Activity is completed.

**Accidental Death and Dismemberment Benefit:** If an Insured's Injury results in any of the following losses within 365 days after the date of accident, We will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident.

<b>Principal Sum:</b> \$10,000	<b>Time Period for Accident for:</b>	Heart Failure	90 Days
		Quadriplegia, Paraplegia, Hemiplegia	60 Days and continuing for one year
		All Other Covered Losses	365 Days

<b>Covered Loss</b>	<b>Benefit Amount</b>
Life, Heart Failure, Hemiplegia, or Paraplegia	100% of the Principal Sum
Quadriplegia, or Two or More Members	200% of the Principal Sum
One Member	50% of the Principal Sum
Thumb and Index Finger of the Same Hand	25% of the Principal Sum

"Heart Failure" means death because the heart ceases to beat due to failure of the heart to maintain adequate circulation of blood provoked by participation in a Covered Activity. "Quadriplegia" means total Paralysis of both upper and lower limbs. "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Paralysis" means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted. "Member" means Loss of Hand or Foot, Arm or Leg, and Loss of Sight. "Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Arm or Leg" means Severance at or above the elbow joint or knee joint. "Loss of Sight" means the total, permanent Loss of Sight of one eye. "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). "Severance" means the complete separation and dismemberment of the part from the body.

**Medical Expense Benefit:** If the Insured requires medical or surgical treatment during the Period of Coverage, We will pay 100% of the Usual and Customary Charges incurred for Covered Expenses listed below, up to a maximum of \$15,000 per covered Accident, and \$7,500 per covered Sickness. The Insured must receive treatment within 60 days after the date of the covered Accident. Benefits are subject to a maximum benefit period of 52 weeks after the date of the covered Accident or first treatment of a covered Sickness.

(Council Plan)

We will pay benefits for the following Covered Expenses: 1) daily hospital room and board payable at the semi-private room rate; 2) ancillary hospital expenses; 3) inpatient registered nurse services; 4) medical emergency care for room & supplies; 5) outpatient surgical room and supplies; 6) Doctor's non-surgical expenses; 7) doctor's surgical expenses; 8) assistant surgeon; 9) anesthesiologist expenses; 10) outpatient laboratory tests; 11) physiotherapy; 12) outpatient x-ray; 13) diagnostic imaging; 14) outpatient registered nurse services; 15) rehabilitative braces and appliances; 16) prescription drugs; and 17) medical services and supplies.

**Dental Expense Benefit (Injury Only):** We will pay 100% of the Usual and Customary Charges incurred for dental services rendered to an Insured, including dental x-rays for the repair, treatment and/or replacement of each injured tooth that is whole, sound and a natural tooth at the time of the Accident, up to a maximum of \$5,000. If, within the 52-week Benefit Period, your attending dentist certifies that dental treatment and/or replacement must be deferred beyond the Benefit Period, We will pay the estimated cost for Covered Expenses incurred for such treatment. We will pay this Benefit in addition to any other Benefit payable under the Policy.

**Ambulance Expense Benefit:** We will pay 100% of the Usual and Customary Charges incurred for ground transportation from the emergency site to the hospital (includes air ambulance when, in the judgment of a duly authorized medical authority or senior representative of the camp or activity, such service is required to facilitate treatment of Injuries and no other ambulance service is available). The maximum amount payable is \$6,000 per covered Accident or Sickness. Benefits are subject to a maximum benefit period of 52 weeks after the date of the covered Accident or first treatment of a covered Sickness. We will pay this Benefit in addition to any other Benefit payable under the Policy.

**Disability Benefit (Applies Only to Class II):** We will pay a weekly benefit of \$200 if an Insured is Totally Disabled as a direct result of, and from no other cause but, a covered Accident or Sickness. Disability Benefits will begin when: 1) the seven-day benefit waiting period is satisfied; and 3) the Insured provides satisfactory proof of Total Disability to Us. Benefit Payments will end on the first of the following dates: 1) the date the Insured dies; or 2) the date the Insured is no longer Totally Disabled; or 3) the date the Maximum Benefit Period for this benefit ends; or 4) the date the Insured fails to submit satisfactory proof of continuing Total Disability.

"Total Disability" or "Totally Disabled" means, due to an Injury from a Covered Accident or Sickness, an Insured: 1) if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and 2) if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.

**Return Transportation Expense Benefit:** We will pay 100% of the Usual and Customary Charges incurred for transportation expenses if, as a result of a covered Accident or Sickness, the Insured's Doctor requires him or her to return home from a Covered Activity. The maximum amount payable is \$1,500 per covered Accident or Sickness. This benefit includes the cost of one person to accompany the Insured on the trip. If the Insured is deceased, We will pay expenses incurred for an immediate family member to accompany the body. Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses, in advance.

**Specified Injury Expense Benefit:** We will pay 100% of the Usual and Customary Charges incurred for the treatment of a) loss of sight in both eyes; b) Dismemberment of any extremity; c) Paralysis; d) irreversible coma; e) entire loss of speech; or f) loss of hearing in both ears, up to a maximum of \$35,000.

"Dismemberment of any extremity" means complete Severance of hand, foot, arm or, leg. "Severance" means the complete separation and dismemberment of the part from the body. "Paralysis" means total loss of use of: a) both upper and lower limbs; upper and lower limbs on one side of the body; one lower limb or one upper limb; or both lower limbs or both upper limbs. "Irreversible Coma" means: a) a state of unconsciousness in which there is a cessation of activity in the central nervous system as demonstrated by an electroencephalogram (using criteria established by the American Electroencephalography Society), and b) a diagnosis of brain death by the attending Doctor.

**Primary Excess Benefit Provision:** We pay the first \$300 of covered Accident Medical Expenses without regard to any other Health Care Plan benefits payable for the Insured. We will then pay expenses: 1) after the Insured satisfies any Deductible; and 2) only when they are in excess of any amounts payable by any other Health Care Plan. We pay benefits without regard to any Coordination of Benefits provisions in any other Health Care Plan. This benefit provision does not apply to Accidental Death and Dismemberment and Total Disability Benefits.

**Exclusions and Limitations:** We will not pay benefits for any loss or Injury that is caused by, or results from: 1) intentionally self-inflicted Injury; 2) suicide or attempted suicide; or 3) war or any act of war, whether declared or not.

In addition to the exclusions above, We will not pay Accident Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by: 1) Treatment by persons employed or retained by a Policyholder, or by any Immediate Family or member of the Insured's household; 2) Eyeglasses, contact lenses, hearing aids, examinations or prescriptions for them, or repair or replacement thereof; 3) Dental treatment or dental X-rays, except when required as the result of Injuries to sound, natural teeth; or 4) Injury paid or payable by Workers' Compensation, Employer's Liability Laws or similar occupational benefits.

To file a Claim, please call: Health Special Risk, Inc. 1-866-726-8870 HSR Plaza 4001 N. Josey Lane, Carrollton, TX 75007-1520

Health Special Risk, Inc. will provide you with instructions on how to file your claim. The Insured must notify Health Special Risk within 90 days of an Accident or loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Insured and the Policy Number.

This Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in Policy Number PTP N00327402, issued to the Boy Scouts of America. The policy is subject to the laws of the state in which it is issued. Please keep this information as a reference.



To be completed by BSA Leader

Council Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

ACE American Insurance Company

BOY SCOUTS OF AMERICA

- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
- 3. MAIL TO HEALTH SPECIAL RISK, INC.

HSR Plaza  
 4001 North Josey Lane  
 Carrollton, TX 75007-1520  
 866-726-8870  
 Fax 972-492-4946

**PART 1 - BSA Leader's Statement**

Check One:  Tiger Cub  Tiger Cub Adult  Varsity Scout  Cub  Scout  Venturer  Leader  Committee  
 Learning for Life - Explorer  Seasonal Staff  Other \_\_\_\_\_

Check Policy:  Council  Unit  Campers & Special Events  National Events

Post Number	Team Number	Troop Number	Pack Number
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1. Name of Insured (Claimant)	2. Social Security Number	3. Sex _F _M	4. Birthday _ / _ / _
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5. Address of Insured Street	City	State	Zip
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6. Parent's name, address and telephone number (include area code)

7. What date did accident happen or sickness begin?	8. Nature of injury or sickness (indicate part of body injured - such as broken arm, sprained ankle, etc.)
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9. Describe how accident occurred - give details

FOR DENTAL CLAIMS ONLY	10. Indicate which teeth were involved in the accident:	11. Describe condition of injured teeth prior to accident: <input type="checkbox"/> Whole, sound and natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial
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12. Name of event or activity	13. Name and title of supervisor
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14. Signature of policyholder representative X	15. Title	16. Date
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**PART 2 - Other Insurance Statement**

Do you/spouse/parent have medical/health care coverage through your employer or other source on you?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:  
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan?  YES  NO  
 If Yes, name of insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:  
 Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES OF THEIR EXPLANATION OF BENEFITS ALONG WITH YOUR CLAIM.**

**IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.**  
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

Signature of participant or parent X	Witness	Date
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**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**Authorization to pay benefits to provider**

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.  
 Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization for release of information**

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.  
 Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS**

## HOW TO SUBMIT A CLAIM

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You have been injured and you need to file a claim for consideration of benefits. How is that done? Below are basic items that need to be included in order to have your claim considered. Please keep in mind that we are not guaranteeing your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.

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There are three basic items that are required in order for a claim to be considered eligible for benefits.

1) **A Completed Claim Form**

Please be sure to neatly and fully complete your claim form. If you do not have a claim form, please call **HSR** for assistance. Your claim form must have a policyholder's authorized signature. The policyholder representative is an employee or other administrator that acts on behalf of the policyholder to verify your claim. The policyholder will typically be your BSA or LFL Leader.

2) **Copies of Fully Itemized Bills**

Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-92 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis code. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

3) **Copies of Your Primary Insurance's Explanations of Benefits**

The policy is excess to any other available source of medical benefits if the charges are greater than \$300.00. This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding. If the total charges are less than \$300.00, we will pay without the other insurance coordination. When your primary insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

***IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Part 2 of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You MUST sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document.***

For specific policy information, please call **HSR** to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has limitations on claim submission as well as on the benefit period, which is the period of time for which benefits are available for treatment for that injury from the date of injury. Treatment received past the benefit period is not eligible for benefits.

### CONTACT INFORMATION

***Health Special Risk, Inc.***  
4001 North Josey Lane  
Carrollton, TX 75007  
Toll Free Number 1-866-726-8870  
Fax Number: 972-492-4946  
Customer Service Email: [claims@hsri.com](mailto:claims@hsri.com)