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

Atlanta Area Council #92

Effective Date: 01/01/11 Expiration Date: 01/01/12
Premium Amount: $ XXXXX Premium Paid: $ XXXXX
Date Paid: 01/14/11 Balance Due: $ XXXXX

Policy Number PTP N00327402

Description of Coverage
Boy Scouts of America Council Accident & Sickness Insurance Plan

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; Venturing Crew, 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 Curriculum-based 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 of 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.

Principal Sum: $10,000

Time Period for Accident for:

Heart Failure	90 Days
Quadriplegia, Paraplegia, Hemiplegia	60 Days and continuing for one year
All Other Covered Losses	365 Days

Benefit Amounts:

Covered Loss	Benefit Amount
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
Speech and Hearing in Both Ears	100% of the Principal Sum
Speech or Hearing in Both Ears	50% of the Principal Sum
Hearing in One Ear	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. "Quadraplegia" 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.

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.

Excess Benefit Provision: The Plan is an Excess Insurance Plan meaning the Plan will pay all those eligible expenses incurred from a covered accident or sickness not paid by any other collectible insurance or prepaid health plan in-force for you or a dependent child(ren). If no other collectible insurance or prepaid health plans are in effect at the time of the loss, this plan will pay all eligible covered expenses up to the plan limits. There is no deductible under this plan. Also, coverage under this plan does not provide duplicate benefits when an insured member is also insured under another Boy Scout or Learning for Life plan for a national or regional sponsored camp or special event. This provision applies to all benefits offered under these plans, including Accidental Death & Dismemberment.

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 the administrator, ***Health Special Risk, Inc.***, toll-free at **1-866-726-8870** or mail your claim to ***Health Special Risk, Inc.*, HSR Plaza II, 4100 Medical Parkway, 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, Inc.*** 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 which is PTP N00327402.

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 (Texas). Please keep this information as a reference.

(Council A&S Plan eff. 2010-09-01)

HOW TO SUBMIT A CLAIM

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully complete and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding **"OTHER INSURANCE STATEMENT"**, marking either yes or no and signing the line for authorization so that ***HSR*** and the doctors/hospitals may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. The claim form must be signed by a policyholder representative (i.e. council, leader).
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records and mail to the address shown below.
5. **DO NOT** assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward their itemized bills to us.
2. If you have already been to the doctor/hospital and did not know about this coverage, please send all of the itemized bills you receive to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw your for and the specific itemized charges incurred.
4. If this information is not on the bill when you send it to us, we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" statements do not contain sufficient information to complete your claim. Mailing ***HSR*** "Balance Due" statements will only delay the processing of your claim.

EXCESS INSURANCE

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 Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

If you have any questions, please contact Customer Service from 8:00 AM thru 5:00 PM, Monday – Friday at (866) 726-8870 or via e-mail at boyscouts@hsri.com. You may also forward any documents by fax to (972) 512-5820.

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, TX 75007

FRAUD STATEMENTS

GENERAL: 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.

ALASKA, ARKANSAS, IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA RESIDENTS: WARNING It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MARYLAND: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

PENNSYLVANIA: 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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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.

E-Mail: boyscouts@hsri.com

HSR
Health Special Risk, Inc.

HSR Plaza
4100 Medical Parkway
Carrollton, TX 75007-1517
Toll Free 866-726-8870
Fax 972-512-5820

To be completed by BSA Leader
Council Name: Atlanta Area Council
Address: 1800 Circle 75 Pkwy, S
Atlanta, GA 30339
Telephone Number: 770-989-8820

ACE American Insurance Company

FOR *HSR* USE ONLY: Claim Company #_____ Plan # _____ Location # _____

PART 1 - BSA Leader's Statement

Check One: ☐ Tiger Cub ☐ Tiger Cub Adult ☐ Varsity Scout ☐ Cub ☐ Scout ☐ Venturer ☐ Leader ☐ Committee
☐ Learning for Life – Explorer ☐ Paid Seasonal Staff ☐ Volunteer Seasonal Staff ☐ Other_____

Check Policy: ☐ Council ☐ Unit ☐ Campers & Special Events ☐ National Events

Pack, Troop, Post, or Team Number	1. Claimant's Name (Injured/Sick Person)	2. Social Security Number - -	3. Gender __M __F	4. Birthday __/__/__

5. Claimant's Address (Street, City, State, Zip Code) and best contact telephone number (include area code)

6. If applicable, parent's name, address and best contact telephone number (include area code)	7. E-Mail

8. What date did accident happen or sickness begin?	9. Nature of injury or sickness (indicate part of body injured – such as broken arm, sprained ankle, etc.)

10. Describe how accident occurred – give details — Did Injury Result in Death? ☐YES ☐NO

11. Name of event or activity	12. Name and title of adult leader

13. Signature of policyholder representative X	14. Title	15. Date

PART 2 – Other Insurance Statement

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

If Yes, name of insurance company _____ Poiicy #_____

Name of second insurance company _____ Policy #_____

Coverage is Primary for First $300.00 Only, Then Excess

This policy is excess to any other available source of medical benefits if the charges are greater than $300.00. You must file your bills through your primary/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 Benefits, or "EOB." Please submit copies of their Explanation of Benefits along with your claim.

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

NOTE: 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 or 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