ALLIANCE OF NONPROFITS FOR INSURANCE

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ALLIANCE OF NONPROFITS FOR INSURANCE RISK RETENTION GROUP (ANI)

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ACCIDENT INSURANCE PROGRAM

MASTER POLICY - MHH010307

Underwritten by: QBE Insurance Corporation

Statement of Coverage

Part 1

PARTICIPATING ORGANIZATION: Missing in America Veterans Recovery Program
6900 Danyuer Rd.
Redding, CA 96001

CONTROL #: 21050

COVERAGE TERM: 07/09/2019 to 07/09/2020

SUMMARY OF BENEFITS

PLAN C

Accidental Death	$50,000
Accidental Dismemberment Maximum	$50,000
Accidental Paralysis	$25,000
Aggregate Limit of Liability	$1,000,000
Excess Accident Medical	$50,000
Deductible	$100

COVERED PERSONS

Volunteers

OPTIONAL COVERED ACTIVITIES

Over 2 Day Outings

ANNUAL PREMIUM: $100

Please refer to Part 2 of the Statement of Coverage for a more complete description of the benefits provided by this program, including program exclusions and limitations.

Date: 7/10/2019

ACCIDENT INSURANCE

STATEMENT OF COVERAGE
Part 2

Underwritten by: QBE Insurance Corporation

This Statement of Coverage confirms that Blanket Accidental Death, Dismemberment, Paralysis and Accident Medical Expense benefits are provided to Covered Persons volunteering, or participating, in activities that are supervised and sponsored by the Participating Organization (Organization) named in Part 1, under Policy # MHH010307, issued by QBE to: Volunteers Insurance Services® Association Alliance Member Services, Nonprofits Insurance Alliance of California, Alliance of Nonprofits for Insurance.

Covered Persons
- All designated, recorded Volunteers participating in a volunteer project through the Organization's program, if Volunteers are listed in Part 1.

- All registered Participants participating in supervised and sponsored Organization activities, if Participants are listed in Part 1.

Covered Activities
Volunteers and Participants are covered while participating in all activities which are supervised and sponsored by the Organization named in Part 1.

Accidental Death, Dismemberment & Paralysis (Plegia) Benefits

Loss of Life	$50,000
Loss of any combination of two: hands, feet, eyesight, speech and hearing	$50,000
Total paralysis of upper and lower limbs, both lower limbs, or upper and lower limbs on one side of the body	$25,000
Loss of one hand, one foot, sight in one eye, speech or hearing	$25,000
Loss of thumb and index finger of same hand	$12,500
Loss of Life due to heart failure	$10,000

Accident Medical Expense Benefits

Maximum Benefits for any one Covered Accident	Refer to Part 1
Benefit Period for any one Covered Accident	52 weeks
Deductible	Refer to Part 1
Scope of Coverage	Excess—pays benefits after any other Health Care Plans have paid benefits
Benefit Amount Payable	100% of Usual and Customary charges, up to Maximum Benefit per Covered Accident
Covered Expenses Include	In & Out-Patient Hospital, Ambulatory Medical Center & Emergency Room, Physician visits & surgery, diagnostic tests, nursing services and ambulance charges
Dental Expenses	$1,000 maximum benefit, up to $300 per tooth

Accidental Death, Dismemberment and Paralysis benefits: Loss of 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 the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means. Loss of a thumb and index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body. Paralysis means loss of use, without severance, of a limb. This loss must be determined by a physician to be complete and not reversible. If the same accident causes more than one of these losses, we will pay the largest amount that applies.

Exclusions and Limitations:

Coverage is not provided for any accident which is caused by or results from any of the following:

- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
- commission or attempt to commit a felony or an assault; commission of or active participation in a riot or insurrection;
- bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
- declared or undeclared war or act of war;
- flight in, boarding or alighting from an aircraft, except as a fare-paying passenger on a regularly scheduled commercial airline;
- travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle; participation in any motorized race or contest of speed;
- an accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless the covered person holds a valid learners permit and the covered person is participating in a driver's education program;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- travel or activity outside the United States or Canada, unless advance written approval is provided;
- the covered person being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred;
- 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;
- injuries compensable under Workers' Compensation law or any similar law;
- an accident which occurs while the covered person is driving a private passenger automobile while intoxicated.
- Benefits will not be paid for any hospital stay that is not considered appropriate treatment for the condition and locality.
- Overnight Supervised and Sponsored Activities and related travel are not covered, unless agreed to in writing by the Company.
- In addition, benefits will not be paid for services or treatment rendered by any person who is employed or retained by the policyholder or living in the covered person's household or provided by a parent, sibling, spouse or child of either the covered person or the covered person's spouse, or the covered person.
- The Accidental Death, Dismemberment and Paralysis aggregate limit of liability is $1,000,000.

Accident Medical Benefit limitations and excluded expenses:

- cosmetic surgery, except for reconstructive surgery needed as the result of a covered injury;
- any elective or routine treatment, surgery, health treatment, or examination;
- blood, blood plasma, or blood storage, except expenses by a hospital for processing or administration of blood;
- examination or prescription for initial eyeglasses, contact lenses or hearing aids;
- treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay;
- services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay;
- rest cures or custodial care;
- repair or replacement of existing dentures, partial dentures, braces or bridgework;
- personal services such as television and telephone or transportation;
- expenses payable by any automobile insurance policy without regard to fault;
- services or treatment provided by an infirmary operated by the policyholder;
- 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;

- treatment or service provided by a private duty nurse;
- treatment of hernia of any kind.
- Treatment of injury resulting from a condition that a covered person knew existed on the date of the accident, unless he received a written medical release from his physician.

Any covered expenses payable under the Accident Medical Expense benefit will be reduced by 50% if the covered person has HMO or PPO coverage and elects not to use that coverage.

Claims Procedures

1. Send the completed and signed QBE Accident Claim Form to the claims administrator as soon as you receive notice that an injury has occurred. The Organization needs to complete and sign Part I. The claimant must complete Part II and sign Part III. Include a copy of Part 1 of the Statement of Coverage with the Claim Form.

2. Since this program provides coverage for medical expenses that are in "excess" of any other Health Care Plan the claimant has, all claims must be submitted to the claimant's primary insurance carrier first. If the claimant has no other insurance, this program will act like primary coverage.

3. Itemized bills for all medical expenses, referred to as a "HCFA" from a doctor's office or a "UB92" from a hospital, must be provided to the claims administrator in order for the claim to be processed.

4. The claimant's primary insurance will send them an Explanation of Benefits (EOB) for all submitted expenses. Copies of all such EOBs must also be submitted to the claims administrator in order for claims to be processed under this program.

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

Toll Free Number: 1-866-408-3361
E-mail: Claims@hsri.com

Important Notice: This information is a brief description of the important benefits and features of the Blanket Accident Medical Insurance underwritten by QBE Insurance Corporation. It is not a contract. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations and exclusions are set forth in the Master Policy.

HSR
Health Special Risk, Inc.

Toll Free Number: 1-866-408-3361

INSTRUCTIONS FOR HAVING CLAIMS PAID QUICKLY AND EFFICIENTLY

Health Special Risk is a Third Party Administrator and processes claims for your organization's Accident policy on behalf of QBE. This is not a liability policy. It is in place to assist you with your medical bills that result from covered accidents. There are three important items that Health Special Risk needs to process your claim. They are:

- A completed and signed QBE Accident Claim Form.
- Itemized bills from Your Medical Care Provider.
- Your Primary Health Insurance Carrier's Explanation of Benefits (EOBs).

1) Complete the QBE Accident Claim Form:

In the event of an accidental injury, please complete the claim form as follows:

Part I – The organization must complete and sign "Part I". **All** fields must be completed in this section. Organization must also provide the claimant with a copy of the first page of the **Statement of Coverage** for submission with the claim form.

Part II - The insured must complete "Part II" and sign "Part III". Since this is excess coverage, the insured's primary medical insurance is a vital piece of information in "Part II". "N/A" cannot be inserted. If the insured has no other insurance, please state "No other insurance".

IMPORTANT: Please include a copy of Page 1 of the Statement of Coverage with the Claim form.

The quickest and easiest way to get items 2 and 3 below to our office, is to simply provide Health Special Risk's contact information to your medical provider and have them bill Health Special Risk as the secondary payor.

Otherwise, you can proceed as follows:

2) Provide copies of your Medical Care Provider's itemized bills:

Health Special Risk needs to review the itemized bills from your provider to confirm that the procedures being performed are appropriate for the injury sustained, as well as that the amount being charged is at a reasonable and customary rate. These bills are often referred to as a "HCFA" from a doctor's office and a "UB92" from a hospital. You can either send these bills in to HSR's office yourself or request that the provider send them to Health Special Risk directly. ***If you already paid these bills and you are requesting reimbursement, please include a copy of your proof of payment, such as the receipt you received from your medical provider.***

3) Provide copies of your Primary Health Insurance Carrier's Explanation of Benefits (EOB):

This coverage is designed to be "excess" of any other medical insurance you have, meaning that QBE's plan will provide coverage for the out of pocket expenses from your primary coverage (deductibles, co-payments, etc) up to the policy limits for covered accident medical expenses. For Health Special Risk to determine what amounts are not being paid by your primary insurance, we need to review your primary carrier's explanation of benefits. Your primary carrier should automatically provide them to you. If they do not, contact them and ask for them, they are required to provide them to you.

Once the claim form has been completed, please mail, fax or email it and any other pertinent information to HSR for processing:

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

Toll Free Number: 1-866-408-3361
Claim Status: Maureen Clark, Sr Claims Processor

Fax: 1-469-701-3020
Email: MaureenClark@hsri.com

QBE Insurance Corporation

Accident Claim Form

Mail/Fax/Scan to

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

E-mail: Claims@hsri.com
Toll free: (866) 408-3361
Fax: (972) 512-5820
MHH010307 ANI

Caution

Any person who, knowingly and with intent to defraud, or helps commit a fraud against, 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 thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. **Residents of the following states, please see last page: CA, CO, DC, FL, NY, TN, TX and VA.**

Instructions

Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You **must** submit your claim to your other insurance company first (this does not apply if the policy provides primary coverage). When you receive their Benefits Statement (EOB) send it to us along with the itemized bills.

- **Part I -** Must be completed by Policyholder.
- **Part II -** Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor.
- Send copies of itemized bills showing provider's name, address, Tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

Part I – Policyholder Report

Name of Policyholder | Control number | Policy number: MHH010307 ANI

Policyholder address | City | State | Zip code

Policyholder contact | Email | Fax | Phone

Last name of Claimant | First name of Claimant | Social Security number | Date of birth

Sex: ☐ Male ☐ Female

Claimant is: ☐ Volunteer ☐ Participant

Nature of injury (Describe, fully indicate what part of body was injured – e.g. broken arm, sprained ankle)
Must be a bodily injury due to accident

Describe how the accident occurred, provide all details. Attach a separate sheet, if necessary (include name of Sport/Activity).

Did accident occur:

While Claimant was Policyholder supervised?	☐ Yes	☐ No
During a Policyholder sponsored activity?	☐ Yes	☐ No
During scheduled Policyholder hours?	☐ Yes	☐ No
While traveling to or from a Policyholder sponsored and supervised activity?	☐ Yes	☐ No
Off Policyholder premises, at home, during the weekend, holiday or summer vacation?	☐ Yes	☐ No

Date of accident | Time of accident ☐ AM ☐ PM | Place of accident | First treatment date

Name and title of person supervising activity? | Was he or she a witness? ☐ Yes ☐ No

List other Policyholder insurance. Attach separate sheet, if necessary. | Policy number(s)

Signature of authorized Policyholder representative | **Title** | **Date**

X

Part II – To be completed by Claimant or Parent / Guardian, if Claimant is a minor

Name of Claimant or Father/Guardian | Social Security number | E-mail address

Name of Mother or Guardian | Social Security number | E-mail address

Street address of Parents or Claimant Guardian | City | State | Zip code

Telephone number | Father or Guardian's insurance company | Mother or Guardian's insurance company

Name and address of Claimant or Father/Guardian's employer, if a minor. | City | State | Zip code

Name and address of Claimant or Mother/Guardian's employer, if a minor. | City | State | Zip code

List all other insurance policies under which Claimant is insured | Policy number

Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).

Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of PPO or organization

Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of HMO or organization

If Claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:

Name of Policyholder | Name of insurance company | Policy number

Affidavit

I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

Authorization to Release Information

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any QBE company, its employees, and authorized agents for the purpose of validation and determining benefits payable. I further authorize any QBE company to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

Payment Authorization

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

Signature (Parent or guardian, if the claimant is a minor) | **Date**

California and Texas residents	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 residents	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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
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 residents	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.
New York residents	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 $5,000 and the stated value of the claim for each such violation.
Tennessee residents	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.
Virginia residents	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.