



Participant Accident (PAI) Program

COVERAGE SUMMARY

INSURER:
QBE Insurance
Company

POLICY TERM:
July 1, 2016 to
July 1, 2017

POLICY NO:
Various – On File With
Company



QUESTIONS:

Robert Leong
(415) 403-1441
rleong@alliant.com

Van Rin
(415) 403-1408
vrin@alliant.com

Hsan Htein
(415) 403-1452
hhtein@alliant.com

NAMED COVERED ENTITY:

Group or organization while engaged in CSU or CSU Auxiliary Organization sponsored activity such as:

1. Athletes – including amateur sports, school sports, sports campus
2. Volunteers – including community and non-profit organizations
3. Child Care Centers – including school and church affiliated centers
4. Recreation – including camping, skiing, white water rafting
5. Charities, fundraisers, religious retreats and meetings
6. One-time special events

COVERAGE FEATURES:

Individual Policy Coverage Limits on file with Company

1. High-limit Accident Medical Expense (AME) benefit maximums – up to \$1,000,000
2. Accident Medical Expense Limits: Primary, Primary Excess or Full Excess
3. Optional Catastrophic Plans – up to \$10,000,000
4. Accidental Death & Dismemberment benefits
5. Medical Evacuation and Repatriation benefits available
6. Choice of benefit levels, deductibles and benefit periods
7. Coverage can be extended to administrators, organizers, trainers or supervisors

DISCLAIMERS:

Coverage exclusions and limitations may apply. Availability and coverage levels of some plan features subject to state laws and underwriting requirements.

HOW TO REPORT A CLAIM:

Written notice must be submitted to Claims Administrators within 30 days after a covered loss occurs or begins.

Health Special Risk, Inc. (HSR)
4100 Medical Parkway
Carrollton, Texas 75007-1517
Phone: (972) 512-5600 Fax: (972) 512-5820
(See attached for further info)



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CSU Participant Accident Coverage

How to file a Participant Accident Claim

Policy #

Effective

Did you know that missing one item on your claim could delay payment? You can help us speed up the claim process by properly completing and mailing required information. The following guidelines will help you in filling out the forms and gathering information:

- CSU, as the Policyholder, must complete, date, and sign **PART I** of the claim form
- It is mandatory for the claimant, parent or guardian to complete **PART II**, including ALL other insurance information in full detail. Please note that **signatures are required of the claimant, parent or guardian.**
- Eligible expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan, they must **first submit claim to the primary insurance.** After the primary insurance has paid benefits, then submit this claim form along with all EOB's (Explanation of Benefits) from the primary insurance. If the claimant has no other insurance submit claim form along with itemized medical bills.
- Attach all medical bills. All submitted medical bills must be itemized for service. **A balance due statement is not acceptable and will only delay processing.** A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.
- You should **make copies** of the completed claim form and all itemized bills that are involved in the claim and **KEEP THEM FOR YOUR RECORDS.**
- In the event that a claim is not submitted in full or if additional information is needed, the claim will be pended and the additional information will be requested by HSR. Please forward the requested information immediately so that the claim can be adjudicated in a swift manner. The Explanation of Benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (I).

While we believe this Summary of Insurance fairly represents the terms, conditions and exclusions found in your insurance policies, in the event of any differences between the policies themselves and this summary, the policy provision will direct any resolution. This summary is not intended to replace or supersede any of your insurance contracts.



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CLAIM SUBMISSION CHECKLIST

Use the checklist below to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company? _____

If the claim has first been submitted to the primary health insurance company, are copies of EOB's (Explanation of Benefits) attached? _____

Is Part (I) of the claim form completed by the Policyholder official or staff member and signed? _____

Is part (II) of the claim form completed by the injured person and signed? _____

Are the attached medical bills in either a CMS 1500 or UB04 form? _____

Is part (I), item number 4 (social security number) completed? _____

Are the attached medical bills in either a CMS 1500 or UB04 form? _____

When the claim form is completed in full, mail the completed claim form, itemized bills and copies of EOB's (Explanation of Benefits) to:

**Health Special Risk
HSR Plaza II
4100 Medical Parkway
Carrollton, TX 75007-1517
Phone: (972) 512-5600
Fax: (972) 512-5820
Toll Free: (866) 523-3186**

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