Volunteer Accident Insurance Program

Volunteer Information:

As a registered OHSU volunteer you may be eligible for accident medical expense benefits if an injury or exposure occurs by accidental* means while performing your volunteer activities at OHSU. Please see the attached list of benefits offered through the Volunteer Accident Insurance Program. Benefits are payable for covered medical expenses that are in excess of benefits paid by any Other Health Care Plan. In the event a volunteer has no other coverage, benefits will be payable on a primary basis.

What do I do if I'm injured or have an exposure while performing my volunteer activities at OHSU?

Please contact your Volunteer Coordinator or Risk Management at riskmgmt@ohsu.edu or 503-494-7189 with any questions or concerns.

Immediately contact your Volunteer Coordinator. The Volunteer Coordinator will provide you with a claim form. Please review the "How to File a Medical Claim" instructions. It is important that if you wish to file a claim that you submit the completed claim form as soon as possible as indicated in the instructions. The claim must be filed timely in order to qualify for benefits.

*** **If you have a possible HIV exposure event while performing your volunteer activities you must complete and send the claim form (see information below) within 24 hours of the exposure to qualify for benefits. You must also receive an antibody test within 24 hours of the exposure. If you have an HIV exposure and you are unable to reach your Volunteer Coordinator immediately, please call the OHSU paging operator at 503-494-9000 and page the Risk Management pager at 11101. **** . Please see the Bloodborne Pathogen Exposure Policy (https://ohsu.ellucid.com/documents/view/89) .**

*"Accident/Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the insured Person is covered under the policy. "

Volunteer Coordinator Information:

- Upon notification of a volunteer accident or exposure, please review the "How to File a Medical Claim" form and complete Part 1. Upon completion of Part 1 of the claim form, please email a copy of the claim form to riskmgmt@ohsu.edu .
- Provide the volunteer with a claim form and "How to File a Medical Claim" instructions along with the attached "Volunteer Accident Insurance Program" information.
- **If the volunteer has a possible HIV exposure, please reiterate to the volunteer that the claim form must be completed and sent within 24 hours of the exposure and that they need to receive an antibody test within 24 hours of the exposure in order to be eligible for any available benefits.**
- Please contact Risk Management at x4-7189 with any questions.

Benefits are payable for covered medical expenses that are in excess of benefits paid by any Other Health Care Plan. In the event the volunteer has no other coverage, benefits will be payable on a primary basis.

Accident Medical Expense Benefit

If an insured person incurs a covered expense due to a covered injury within 365 days from the date of a covered accident, benefits are payable at 100% of the usual and customary charge, up to the Accident Medical Benefit Maximum selected. The first covered expense must be incurred within 60 days of a covered accident.

Covered expenses include:

• hospital confinement, including room and board (limited to the average semi-private room rate) and hospital miscellaneous expenses;
• intensive care room and board expenses (This payment is in lieu of payment for hospital room and board expenses.);
• inpatient and outpatient physician visits;
• surgical expenses (Two or more surgical procedures through the same incision will be considered as one procedure. However, the Company will pay up to 150% of the benefit for surgical procedure when more than one surgical procedure is performed during the same surgical session through different operating fields);
• emergency room expenses;
• nursing services;
• x-ray, CT scan, MRI and laboratory tests;
• outpatient medical services and supplies;
• inpatient and outpatient physiotherapy;
• ambulance expenses (ground or air);
• expenses for medical equipment; and
• dental expenses, including x-rays and oral surgery.

Accidental Death, Dismemberment and Paralysis Benefits Included in all Plans

If, within 365 days from the date of the accident, a covered injury results in any of the losses specified, this program will pay the benefit amount listed below in addition to the applicable Accident Medical Expense benefits.
If the same accident causes more than one of these losses, benefit for the largest amount will be paid.
Loss of Life $25,000
Total Paralysis of upper and lower limbs, both lower

limbs, or upper and lower limbs on one side of the body $50,000
Loss of any combination of two hands, feet or eyes $50,000
Loss of one hand, one foot or sight in one eye $25,000
Loss of thumb and index finger of same hand $12,500

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 the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of 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. Paralysis must be determined by a doctor to be complete and not reversible.

Daily Hospital Benefit

While the insured person is confined in a hospital as a result of a covered accident, Insurance Plans 2 and 3 will pay a daily benefit amount for each day of continuous confinement from the first day of confinement for up to 365 days for each covered accident. Benefits will be payable in addition to any other benefits payable to the insured person.
Confinement must begin within 3 days of the covered accident and must be at the direction and under the care of a physician.

HIV Assigned or Volunteer Duties Accident Benefit

If the insured person suffers a covered loss and tests positive for Human Immunodeficiency Virus (HIV) within one year of the covered accident, benefits will be payable as shown subject to the applicable conditions and exclusions.

Hepatitis Assigned or Volunteer Duties Accident Benefit

If the insured person suffers a covered loss and tests positive for Hepatitis B, Hepatitis C, Hepatitis D within one year of the covered accident, benefits will be payable as shown subject to the applicable conditions and exclusions.
If the insured person tests positive for HIV and Hepatitis B, C or D as a result of the same covered accident, only one benefit amount, the largest, will be paid.

Bereavement and Trauma Counseling Benefit

If the insured person requires bereavement and trauma counseling due to a death or loss covered under the policy, benefits will be payable at $100 per session, for up to a maximum of 10 sessions, subject to the applicable conditions and exclusions. Counseling expenses must be incurred within 30 days of the covered loss.

Benefit	Maximum Benefit
Accident Medical Expense	$25,000
Accidental Death	$25,000
Accidental Dismemberment	up to $50,000
Paralysis	$50,000
Daily Hospital Confinement	$250
HIV	$25,000
Hepatitis	$25,000
Bereavement & Trauma Counseling	up to $1,000

How to file a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies)

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:
NAHGA Claim Services
PO Box 189
Bridgton, ME 04009
Phone: 800-952-4320
Email: claims@nahga.com
Fax: 207-647-4569

Step 1: **Submit a completed Notice of Claim (claim form) via either by mail, email or by facsimile.**

The Participating Organization (not the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Report.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

The Parent/Guardian or Adult Claimant should:

- Fully answer each item in Part II, Other Insurance Statement.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). This does not apply if our policy provides primary coverage.**

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.

- The acceptance of a claim form by an Insurance company is not an admission of coverage

- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.

- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges).

- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO: NAHGA Claim Services
PO Box 189
Bridgton, ME 04009

Phone Number: 800-952-4320
Fax Number: 207-647-4569
Email: claims@nahga.com

In NY, network access provided by MagnaCare. Outside the MagnaCare network, access will be provided by First Health.

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number: SRPO-20365-3054	Organization Name: Oregon Health & Science University	Event, Activity or Sport:

Claimant's Name (Injured Person)	Gender ☐M ☐F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a: ☐ Participant ☐ Staff Member ☐ Other

Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐YES ☐NO

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐YES ☐NO
B. On activity premises? ☐YES ☐NO
C. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
D. During a participating organization practice? ☐YES ☐NO or competition? ☐YES ☐NO

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you 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 an employer, a parent's employer or other source? ☐YES ☐NO

If Yes, name of insurance company::______________________________ Policy #:______________

Mother's (Guardian's) primary employer name, address & telephone: ______________________________

Father's (Guardian's) primary employer name, address & telephone: ______________________________

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐YES ☐NO If yes, please explain: ______________________________

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. This does not apply if the policy provides primary coverage.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE ______________________________ **DATE** ______________

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning 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 or all such records in their entirety to ***AXIS Insurance Company*** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.
I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***AXIS Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE ______________________________ **DATE** ______________

Important Notice

- ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** 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.

- ***For residents of 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.

- ***For residents of the District of Columbia:*** *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.

- ***For residents of 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.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

- ***For residents of Maine, Tennessee, Virginia and Washington:***
  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.

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

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of 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.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.