

Dental & Vision Benefits Summary

Policy Effective Dates:

08/15/2025 through
08/14/2026

Academic Dates:

08/15/2025 through
06/14/2026

RUMSEY HALL SCHOOL

Policy # CC005582

This is a summary of dental and vision benefits contained in your International Student Injury and Sickness Insurance plan.

The benefits listed below for Dental and Vision do not utilize the United Healthcare provider network.

You can visit **any** dentist or vision provider of your choice. Please note that some providers will submit claims directly to TSS, or you may be required to pay for the services upfront. If you pay for the services, you can file a claim to TSS for reimbursement.



Scan this QR code to access the Brochure.

IMPORTANT: Do not submit any claims to United Healthcare for dental or vision services.

How to Submit a Claim

Dental and Vision providers must submit a claim form or itemized bill and include the provider's tax ID#, and the appropriate dental or vision billing codes (Claims will be denied without this information).

Submit to:

TSS Administrative Services, Inc.
PO Box 211008
Eagan, MN 55121
Payor ID: 68251

Via email at: claimsassist@tssassist.com

Member portal at: www.totalscholasticsolutions.com

Reimbursement Method

The primary reimbursement method is a check mailed to the student at the school.

Families who would like to be reimbursed directly have the option to:

- Set up a TSS Member Portal Account
- Submit Claims through the Member Portal
- Request claims to be paid via ACH or Check (Note: Wire Transfer is not available for the 24/25 policy year)
- Legal guardians can submit a claim form and request a different U.S. mailing address for check payments upon approval.

Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this summary of coverage. This plan contains both insurance and non-insurance benefits. Complete provisions pertaining to the insurance portion of the plan are contained in the policy. In the event of any conflict between this summary of coverage and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of your plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to your school. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA compliant insurance coverage. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster SPC.

Pediatric Dental Benefits

The following Benefits are covered dental services for an Insured under age 26.

Dental Care Services	Benefit
Maximum Benefit per Policy Year	\$1,000
Diagnostic Services	100% UCR
Preventive Services	100% UCR
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery Adjunctive Services	100% UCR
Major Restorative Services	100% UCR
Medically Necessary Orthodontics	100% UCR

Scan the QR Code on page one for further details on coverages.

Pediatric Dental Exclusions

In addition to any of the exclusions listed within, for eligible expenses under Pediatric Dental this Insurance also does not cover the following:

- Dental services that are not Necessary.
- Hospitalization or other facility charges.
- Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any dental procedure not directly associated with dental disease.
- Any dental procedure not performed in a dental setting.
- Procedures that are considered to be Experimental or Investigational. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational service in the treatment of that particular condition.
- Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue, except as specifically provided in the policy.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision, except as specifically provided in the policy.
- Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
- Charges for not keeping a scheduled appointment without giving the dental office 24 hours' notice.
- Dental services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the Policy terminates.
- Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
- Expenses incurred for services or treatment outside of the United States.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Plan.

Pediatric Vision Benefits

The following Benefits are covered vision services for an Insured under age 26.

Vision Care Service	Frequency of Service	Benefit
Maximum Benefit		\$1,000
Routine Vision Examination or Refraction only in lieu of a complete exam	Once per year	100% UCR
Eyeglass Lenses	Once per year	
• Single		100% UCR
• Vision		100% UCR
• Bifocal		100% UCR
• Trifocal		100% UCR
• Lenticular		100% UCR
Lens Extras	Once per year	
• Polycarbonate Lenses		100% UCR
• Standard scratch-resistant coating		100% UCR
• Oversized Lenses		100% UCR
Eyeglass Frames	Once per year	
• Eyeglass frames with a retail cost up to \$250		100% UCR
Contact Lenses	Limited to a 12-month supply	
• Covered Contact Lens Selection		100% UCR
• Necessary Contact Lenses		100% UCR
Low Vision Services	Once every 24 months	
• Low Vision Testing		100% UCR
• Low Vision Therapy		100% UCR

Scan the QR Code on page one for further details on coverages.

Pediatric Vision Exclusions

In addition to any of the exclusions listed within, for eligible expenses under Pediatric Vision, this Insurance also does not cover the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the Policy, except as specifically provided in the Policy.
2. Non-prescription items (e.g., Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional lens extras not listed in the Schedule of Benefits.
5. Missed appointment charges.
6. Applicable sales tax charged on vision care services.

Questions? Or Need Help?

Contact the plan administrator at info@shipsignup.com

+1-888-342-2224 • +1-843-342-3150

Clifford Allen Associates, PO Box 23615, Hilton Head Island, SC 29925

After hours:

Contact TSS Assist at assist@tssassist.com

+1-800-730-2417

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This insurance is not subject to and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether this policy meets any obligations you may have under PPACA.