2025-2026

International Student Injury and Sickness Insurance Plan

Network Premier Plus Plan

Designed especially for the
International Students attending
Private Secondary Schools

CAA
CLIFFORD ALLEN ASSOCIATES, LTD.

TSS
Total Scholastic Solutions

20241018-3931514

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us (800) 730-2417.

Eligibility

Who is Eligible: Any student, holding an F1 or J1 visa, or whose permanent residence is not in the United States, and who is affiliated with a private secondary school of the participating organization in the United States, is eligible to purchase and participate in the Plan.

To Be Eligible, the Student Must Be:

Enrolled in credit courses, and actively attending classes or a school sponsored camp or program of the participating organization.

The Company maintains its right to investigate student status to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is a refund of premium.

Effective and Termination Dates

Each participating private secondary school may have a different effective date. The policy allows for an effective date no earlier than July 1, 2025, and not later than September 30, 2025. Coverage is available for 12 months from the school's effective date. The Plan Participant should check with the school they are attending for specific dates of coverage.

Coverage becomes effective on the first day of the period for which premium is paid or at 12:01 am on the student's chosen effective date, whichever is later. Coverage terminates at 11:59 pm on the student's chosen termination date, the date the Plan Participant ceases to be eligible, or at the end of the period through which premium is paid, whichever is earlier.

The coverage is provided by a Non-Renewable Term Policy.

Pre & Post Policy Year Enrollment Options

Coverage is available for purchase to newly enrolled students who arrive in the United States prior to the beginning of the first term of study at their private secondary school, or Insured Persons who have completed their final term of study at their private secondary school and are either preparing to return to the Home Country or attend a college or university in the United States. This option provides up to 60 days of pre or post coverage.

Extension of Benefits after Termination

If the Plan Participant is under the care of a Physician and Hospital confined when the coverage terminates, Benefits will continue to be paid for that condition for up to 90 days, or until the maximum benefit has been paid, whichever occurs first.

Pre-Notification

TSS Assist should be notified of all Hospital Confinements prior to admission.

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS: The patient, Physician or Hospital should telephone 1-800-730-2417 at least five working days prior to the planned admission.

2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS: The patient, patient's representative, Physician or Hospital should telephone 1-800-730-2417 within two working days of the admission to provide notification of any admission due to Medical Emergency.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy and no penalties will be applied; however, pre-notification is not a guarantee that benefits will be paid.

General Features and Plan Specifications

Accident and Sickness Medical Expense Benefits	
Area of Coverage	Worldwide, except student's home country
In-Network Provider	United HealthCare*
Maximum Benefit	Unlimited
Deductible	$0
In-Network Coinsurance	100% of the Preferred Allowance, except as noted below
Non-Network Coinsurance	80% of Usual, Reasonable and Customary (URC) Charges, except as noted below

If a Covered Person receives care In-Network, any Covered Expenses will be paid at the In-Network Provider level of benefits. If a Network Provider is not available within the Covered Person's Network Area, benefits will be paid at the level of benefits shown as In-Network Provider benefits. If the Covered Expense is incurred due to an Emergency Treatment, benefits will be paid at the In-Network Provider level of Benefits. In all other situations, reduced, or lower benefits will be provided when a non-Network provider is used. *****Networks are not provided by Crum & Forster, SPC.

Schedule of Benefits

Benefits will be paid up to the Maximum Benefit for each service in the Schedule of Benefits, below:

Hospitalization and Inpatient Benefits		
	In-Network Provider Benefit	**Non-Network Provider Benefit**
Hospital Room & Board Benefit *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*	100% of Preferred Allowance	80% of the Semi-Private Room 'Rate'
Hospital Miscellaneous Expense Benefit	100% of Preferred Allowance	80% of URC

	In-Network Provider Benefit	Non-Network Provider Benefit
Intensive Care Unit	100% of Preferred Allowance	80% of URC
Surgeon Benefit *When 2 or more procedures are performed through the same incision, the Maximum Benefit will not exceed 50% of the 2nd procedure, and 50% of all subsequent procedures*	100% of Preferred Allowance	80% of URC
Assistant Surgeon Benefit	100% of Preferred Allowance up to 30% of surgeon allowance	80% of URC up to 30% of surgeon allowance
Anesthesia Benefit	100% of Preferred Allowance	80% of URC
Pre-Admission Testing Benefit – payable within 7 days prior to admission	100% of Preferred Allowance	80% of URC
Physiotherapy	100% of Preferred Allowance	80% of URC
Alcohol & Drug Abuse Expense Benefit *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*	100% of Preferred Allowance	80% of URC
Mental & Nervous Conditions Expense Benefit *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*	100% of Preferred Allowance	80% of URC

Emergency Benefits		
	In-Network Provider Benefit	**Non-Network Provider Benefit**
Emergency Room Benefit	100% of Preferred Allowance	80% of URC
Ambulance Services	100% of Preferred Allowance	80% of URC *Out of network ambulance services paid at 100% if treatment is deemed emergent*
Non-Routine Dental Benefit Treatment *Limited to accidental injury to sound natural teeth sustained while coverage is in force*	100% Preferred Allowance	80% of URC

Outpatient Benefits		
	In-Network Provider Benefit	**Non-Network Provider Benefit**
Surgeon Benefit *When 2 or more procedures are performed through the same incision, the Maximum Benefit will not exceed 50% of the 2nd procedure, and 50% of all subsequent procedures*	100% of Preferred Allowance	80% of URC
Assistant Surgeon Benefit	100% of Preferred Allowance up to 30% of surgeon allowance	80% of URC up to 30% of surgeon allowance
Day Surgery Miscellaneous Benefit	100% of Preferred Allowance	80% of URC
Physician Benefit	100% of Preferred Allowance	80% of URC
Consultant Physician Fees	100% Preferred Allowance	80% of URC
Nursing Services	100% of Preferred Allowance	80% of URC
Injections Benefit *When administered in the Physician's office and charged on the Physician's statement*	100% Preferred Allowance	80% of URC
Wellness Medical Expense Benefit *Includes routine exams, sports physicals, and preventive care* *In-Network not subject to Deductible*	100% Preferred Allowance	80% of URC
Urgent Care Benefit	100% Preferred Allowance	80% of URC
Athletic Sports Benefit *Includes coverage for interscholastic, intramural, club, recreational and individual play*	100% Preferred Allowance	80% of URC
Physiotherapy *60 visit maximum per Policy Year – Medical review after 45 visits*	100% of Preferred Allowance	80% of URC
Durable Medical Equipment	100% Preferred Allowance	80% of URC
Diagnostic X-Ray and Lab Benefit	100% Preferred Allowance	80% of URC
Radiation/Chemotherapy Therapy	100% Preferred Allowance	80% of URC

	In-Network Provider Benefit	Non-Network Provider Benefit
Outpatient Prescription Drug Expense Benefit • *Up to 30-day supply per prescription* • *Includes contraceptives* • *No mail order available*	$0 copay per prescription *(When utilizing a CVS Caremark Pharmacy)*	100% of Charges
Diabetes Treatment Expense Benefit	100% Preferred Allowance	80% of URC
Maternity and Pre-Natal Care Expense Benefit	100% Preferred Allowance	80% of URC
Alcohol & Drug Abuse Expense Benefit	100% Preferred Allowance	80% of URC
Mental & Nervous Conditions Expense Benefit	100% Preferred Allowance	80% of URC
Emergency Medical Evacuation/Return of Remains	100% of actual expense	100% of actual expense

Accidental Death and Dismemberment

If within 365 days from the date of an Accident covered by the Policy, an Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which He/She/They is/are entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Any benefit payable under this part will be in addition to any benefit otherwise payable under the Policy. This benefit is subject to all of the definitions, limitations, exclusions and other provisions of the Policy.

Principal Sum	$10,000
Time Period for Loss	365 Days

Loss of:	Benefit: Percentage of Principal Sum
Life	100%
Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or One Foot and Entire Sight of One Eye	100%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Thumb and Index Finger of Same Hand	25%

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 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.

Prescription Drug Information

Prescription Drug Expense Benefit

Benefits are available for outpatient Prescription Drugs, subject to the benefit amounts shown in the Schedule of Benefits, if any, for a Prescription Drug or medication when prescribed by a Physician on an Outpatient basis when dispensed by a CVS/Caremark pharmacy.

Prescription Medication must be obtained from a CVS/Caremark pharmacy

Present your Medical Identification card to the pharmacist, at the time of purchase. The pharmacy will bill TSS directly for your prescription. See the section titled, "How to File a Claim" for information on Prescription Medication Claims. A list of participating pharmacies can be viewed at: www.totalscholasticsolutions.com

Description of Accident and Sickness Medical Benefits

Hospital Room & Board Benefit: Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation. *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*

Hospital Miscellaneous Expense Benefit: Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

Intensive Care Unit/Pediatric Care Benefit: This benefit will include expenses for confinement in an Intensive Care Unit. This is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

Surgeon (in or outpatient) Benefits: This benefit includes expenses for a Physician for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, we will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, we will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Assistant Surgeon Benefit: This benefit includes expenses, if in connection with an operation, the services of an Assistant Surgeon are required.

Anesthesia Benefit: This benefit includes pre-operative screening and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.

Pre-Admission Testing Benefit: We will pay benefits for charges for Pre-admission testing (Inpatient confinement must occur within 7 days of the testing).

Physiotherapy Expense Benefit: Means charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist. Charges include treatment

and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy. 60 outpatient visits maximum per Policy Year – Medical review after 45 visits

Emergency Room Benefit: Means a trauma center or special area of a Hospital that is equipped and staffed to give people Emergency Treatment on an Outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

Ambulance Benefit: Use of a community or Hospital ambulance for Emergency Treatment within the metropolitan area at the time of service. Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Emergency Treatment to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

Non-Routine Dental Expense Benefit: Dental treatment due to sustaining an Injury to natural teeth, while coverage is in force. Only expenses for non-routine dental treatment to natural teeth will be reimbursed.

Day Surgery Miscellaneous Benefit: Services and supplies such as the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an Outpatient basis.

Physician Visit Benefit: Inpatient or Outpatient.

Consultant Physician Benefit: Must be deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis.

Nursing Services: Outpatient Charges for nursing services by a Nurse.

Injections Benefit: Injections, when administered in the Physician's office and charged on the Physician's statement. This does not include immunizations for preventive care or surgical injections. *Immunizations for preventive care are provided as specified under Wellness Medical Expense Benefit.*

Wellness Medical Expense Benefit: Coverage is limited to the following expenses incurred subject to Exclusions. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include: 1. Routine physical examinations: which includes, routine physical examination, sports physical, laboratory tests, x-rays and blood pressure screening 2. Preventive medical attention includes annual screening mammogram; an annual cervical screening for women; a gynecological exam for women; Immunizations and vaccines; contraceptive Devices.

Urgent Care Benefit: Means a walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional Emergency Room. Urgent care centers primarily treat Injuries or Sicknesses requiring immediate care**,** but not serious enough to require an Emergency Room visit.

Athletic Sports Activity Benefit: Any treatment resulting from participating in Interscholastic, intramural, club, recreational and individual play.

Durable Medical Equipment Expense Benefit: Includes the purchase or rental of Durable Medical Equipment. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied

toward the cost of the purchase price if the equipment is purchased at a later date. We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment: Includes oxygen and equipment, braces and appliances and medical equipment that: 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use; 2) can withstand long-term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision.

Diagnostic X-Ray Benefit: Diagnostic x -ray examinations and services.

Laboratory Benefit: Laboratory testing and services.

Radiation/Chemotherapy Therapy Expense Benefit: For services and drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as: 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm; 2) the drug is approved by the FDA for use in antineoplastic therapy; 3) the drug is used as part of an antineoplastic drug regimen; 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and 5) the Physician has obtained informed consent from the patient or parent, guardian, or Power of Attorney for the treatment regimen that includes FDA-approved drugs for off-label indications.

Outpatient Prescription Drug Benefit: Prescription Drug means a drug which: 1) Under Federal law may only be dispensed by written prescription; and 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration. The Prescription Drug must be dispensed for the Outpatient use by the Covered Person: 1) On or after the Covered Person's Effective Date; and 2) By a licensed pharmacy provider.

Diabetes Treatment Expense Benefit: Means Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Physician. Such supplies include blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar. We also cover charges for expenses incurred for diabetes self-management education.

Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the Covered Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Physician or the Physician's office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Maternity and Pre-Natal Care Expense Benefit: Covered Expenses incurred before, during, and after delivery of a Newborn Infant, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Covered Person and her Newborn Infant in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Covered Person's attending Physician determines further Inpatient postpartum care is not necessary for the Covered Person or her Newborn Infant provided the following are met:

1) In the opinion of the Covered Person's attending Physician, the Newborn Infant meets the criteria for medical stability in the latest edition of "Guidelines for Perinatal Care" prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of: a) The antepartum, intrapartum, postpartum course of the mother and Newborn Infant; b) The gestational stage, birth weight, and clinical condition of the Newborn Infant; c) The demonstrated ability of the mother to care for the Newborn Infant after discharge; and d) The availability of post discharge follow up to verify the condition of the Newborn Infant after discharge; and
2) One (1) at-home post-delivery care visit is provided to the Covered Person at her residence by a Physician or Nurse performed no later than forty-eight (48) hours following discharge of the Covered Person and her Newborn Infant from the Hospital. Coverage for this visit includes, but is not limited to, a) Parent education; b) Assistance in training in breast or bottle feeding; and c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Covered Person or Newborn Infant, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Covered Person's discretion, this visit may occur at the Physician's office.)

Alcohol and Drug Abuse Expense Benefit: We will pay for such treatment as follows:

Inpatient Hospital Confinement: Means (i) a Hospital; or (ii) a Detoxification Facility for the treatment of Alcohol Abuse or Drug Abuse. The Confinement must be in a licensed or certified facility, including Hospitals. *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*

Outpatient Alcohol and Drug Services: For the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency. Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an Outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Covered Person needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely Intoxicated individual to fulfill the physical, social and emotional needs of the individual by: a) monitoring the amount of alcohol and other toxic agents in the body of the individual; b) managing withdrawal symptoms; and c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

Mental and Nervous Conditions Expense Benefit: For treatment of a Mental or Nervous Condition as follows:

Benefits for Inpatient Hospital Confinement: The confinement must be in a licensed or certified facility, including Hospitals. *Medical and Eligibility review is required after 90 days of continuous Inpatient residential treatment.*

Outpatient treatment of Mental and Nervous Conditions: The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary. Outpatient treatment and Physician services include charges made by an Outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law. One visit per day.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness. We will pay the covered percentage of the Covered Expenses incurred for treatment of biologically based mental Sickness, including: a) Schizophrenia; b) Schizoaffective disorder; c) bipolar affective disorder d) major depressive disorder; e) specific obsessive-compulsive disorder; f) delusional disorders; g) obsessive compulsive disorders; h) binge eating, anorexia and bulimia; and i) panic disorder.

Emergency Medical Evacuation: If the local attending legally qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment. If the Covered Person is traveling alone and will be hospitalized for more than 4 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, economy transportation, for a single visit to and from the Covered Person's bedside.

Return of Remains: A benefit for Repatriation of mortal remains is included. This benefit excludes fees for return of personal effects, religious or secular memorial services, clergymen, flowers, music, announcements, guest expenses and similar personal burial preferences. The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country will be coordinated by TSS Assist.

Definitions

For the purposes of the Policy the capitalized terms used are defined as follows. This is a summary of definitions. For the complete list, please see the Policy on file with your school.

Accident means an unforeseeable and unexpected event which causes Injury to one or more Plan Participants.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Coinsurance means the percentage of Covered Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means Crum & Forster SPC on and behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Covered Expense means charges:

a) Not in excess of Usual, Reasonable and Customary charge; or Preferred Allowance;
b) Not in excess of the maximum benefit amount payable per service as shown in the Schedule;
c) Made for medical services and supplies not excluded under the Policy;
d) Made for services and supplies which are Medically Necessary; and
e) Made for medical services specifically included in the Schedule.

Covered Expense must be incurred by the Plan Participant while the Policy is in force.

Plan Participant means a person eligible for coverage as identified in the Schedule of Benefits for whom proper premium payment has been made, and who is therefore insured under the Policy.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Emergency/Emergency Treatment means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a Pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Home Country means the country where the Plan Participant has his or her true, fixed, and permanent home

and principal establishment.

Hospital means an institution licensed, accredited or certified by the State that:

1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by a Nurse on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either
   a. on its premises; or
   b. in facilities available to it, on a pre-arranged basis;
6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1) the Joint Commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Immediate Family means a Plan Participant's parent (includes Step-parent), brother, sister, grandparents. A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Injury means bodily harm resulting, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

In-Network Provider means a Physician, Hospital and other healthcare providers who are a member of the designated PPO network contracted with Us to provide medical services to the Covered Person.

Inpatient means a Covered Person who incurs medical expenses for at least one day's room and board from a Hospital; or more than 23 hours in an Observation Unit**.**

Intensive Care Unit means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Maximum Benefit means the largest total amount of Covered Expenses that the Company will pay for the Covered Person as shown in the Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;

2) Prescribed or ordered by a Physician or furnished by a Hospital;
3) Performed in the least costly setting required by the condition;
4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an Outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered 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 consider the cost of the alternative to be the Covered Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Covered Person's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost-effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Plan Participant.

Natural Teeth means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Non-Network Provider means a Physician, Hospital and other healthcare providers who are not a member of the designated PPO network contracted with Us to provide medical services to the Plan Participant.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Physician means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, or a Plan Participant's Immediate Family.

Physical Therapy means any form of the following administered by a Physician:

1) physical or mechanical therapy;

2) diathermy,
3) ultra-sonic therapy;
4) heat treatment in any form; or
5) manipulation or massage

Preferred Allowance means the contractually agreed upon amount an In-Network Provider will accept as payment in full for Covered Expenses.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law and approved for general use by the Food and Drug Administration.

Sickness means illness or disease which requires treatment by a Physician while covered by the Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Usual, Reasonable and Customary means the maximum amount the Policy is obligated to pay for services. Usual, Reasonable, and customary charges will be the lowest of:

1. The billed charge for the services.

2. An amount determined using current data reflecting the costs for providers/facilities providing the same or similar services, adjusted for geographical area surrounding the provider.

Usual, Reasonable, and Customary Charges will be calculated at the 90th percentile (meaning the limit should cover what 9/10 providers charge for that service in their area). No payment will be made under the Policy for any expenses incurred which are in excess of Usual and Customary Charges.

We, Our, Us means Crum & Forster SPC on and behalf of ITI SP.

Accident and Sickness Medical Expense Exclusions

The Policy does not cover any loss resulting from any of the following:

1. Expenses incurred for treatment while in Your Home Country.
2. Charges that are not Medically Necessary.
3. Charges which are in excess of Usual, Reasonable and Customary charges.
4. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply as follows:
   - When due to a covered Injury or Sickness;
   - Except as specifically provided in the Policy.
5. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident, except as specifically provided in the Policy.
6. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
   - Immunization agents, except as specifically provided in the Policy. Biological sera. Blood or blood products administered on an outpatient basis.
   - Drugs labeled, "Caution – limited by federal law to investigational use" or experimental drugs.
   - Products used for cosmetic purposes.
   - Anabolic steroids used for body building.

- Anorectic – drugs used for the purpose of weight control.
- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Growth Hormones.
- Refills in excess of the number specified or dispensed after one (1) year of the date of the prescription.

7. Hearing examinations. Hearing aids. Cochlear implants. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to hearing defects or hearing loss as a result of an infection or Injury.
8. Speech therapy, except as specifically provided in the policy.
9. Hospice Care, Rest cures or Custodial Care.
10. Medical expenses resulting from a motor vehicle accident which is payable under any other valid and collectible insurance.
11. Elective or Cosmetic surgery and Elective Treatment (except as specifically provided); except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered Cosmetic Surgery unless it results from a covered Injury or Sickness).
12. War or any act of war, declared or undeclared.
13. Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal act.
14. Voluntary, active participation in a riot or insurrection.
15. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers.
16. Treatment paid for or furnished under any other individual or group policy, or under any mandatory government program or facility set up for the treatment without cost to any individual.
17. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant.
18. Charges provided at no cost to the Plan Participant.
19. Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes.

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

Pediatric Dental Benefits Services:

Benefits are provided for the following covered dental services for an Insured under the age of 26.

Diagnostic Services:

1. Intraoral Bitewing Radiographs (Bitewing X-ray) - Limited to 1 series of films per 12-months
2. Panorex Radiographs (Full Jaw X-Ray) or Complete Series
3. Radiographs (Full Set of X-Rays) - Limited to 1 time per 36 months
4. Periodic Oral Evaluation (Checkup Exam)
5. Limited to 2 times per 12-months. Covered as a separate benefit only if no other services were performed during the visit other than X-rays.

Preventive Services:

1. Dental Prophylaxis (cleanings) - Limited to 2 times per 12-months
2. Fluoride Treatments - Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.
3. Sealants (Protective Coating) - Limited to once per first or second permanent molar every 36 months
4. Space Maintainers (Spacers) - Benefit includes all adjustments within 6 months of installation

Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery:

1. Amalgam Restorations (Silver Fillings) - Multiple restorations on one surface will be treated as a single filling.
2. Composite Resin Restorations (Tooth Colored Fillings) - For Anterior (front) teeth only.
3. Endodontics (Root Canal Therapy).
4. Periodontal Surgery - Limited to one quadrant or site per 36 months per surgical area.

5. Scaling and Root Planning (Deep Cleanings) - Limited to 1 time per quadrant per 24 months.
6. Periodontal Maintenance (Gum Maintenance) - Limited to 4 times per 12-month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.
7. Simple Extractions (simple tooth removal) - Limited to 1 time per tooth of lifetime.
8. Oral Surgery, including Surgical Extraction.

Adjunctive Services:

1. General Services (including Dental Emergency treatment).
2. Covered as a separate benefit only if no other service was done during the visit other than X-rays.
3. General anesthesia is covered when clinically necessary.
4. Occlusal guards limited to 1 guard every 12-months.

Major Restorative Services:
Replacement to complete dentures, fixed, or removable partial dentures, crowns, inlays, or onlays previously submitted for payment is limited to 1 time per 60-months from initial or supplemental placement.

1. Inlays/Onlays/Crowns (Partial to Full Crowns) - Limited to 1 time per tooth per 60-months. Covered only when silver fillings cannot restore the tooth.
2. Fixed Prosthetics (bridges) - Limited to 1 time per 60-months. Covered only when a filling cannot restore the tooth.
3. Removable Prosthetics (Full or partial dentures) - Limited to 1 time per 60-months. No additional allowances for precision or semi-precision attachments.
4. Relining and Rebasing Dentures - Limited to repairs or adjustments performed more than 12-months after the initial insertion. Limited to 1 per 6-months.

Implants:

1. Implant Placement - Limited to 1 time per 60-months.
2. Implant Supported Prosthetics - Limited to 1 time per 60-months.
3. Implant Supported Prosthetics - Limited to 1 time per 60-months.
4. Implant maintenance procedures - Includes removal of prosthesis, cleansings of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60-months.
5. Repair Implant Supported Prosthesis by Report - Limited to 1 time per 60-months.
6. Abutment Supported Crown (Titanium) or Retainer Crown for FPD-Titanium - Limited to 1 time per 60-months.
7. Repair Implant Abutment by Support - Limited to 1 time per 60-months.
8. Repair Implant Abutment by Support - Limited to 1 time per 60-months.
9. Radiographic/Surgical Implant by Report - Limited to 1 time per 60-months.

Medically Necessary Orthodontics:

Benefits are provided for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefit are not available for comprehensive orthodontic and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be Pre-Authorized. Orthodontic services include, but not limited to:
Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.]

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:

1. Dental services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. 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.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. 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.
8. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
9. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue, except as specifically provided in the policy.
10. 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.
11. 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.

12. 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.
13. Charges for not keeping a scheduled appointment without giving the dental office 24 hours' notice.
14. 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.
15. 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.
16. Expenses incurred for services or treatment outside of the United States.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
20. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
21. 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 • Single Vision • Bifocal • Trifocal • Lenticular	Once per year	100% UCR
Lens Extras • Polycarbonate Lenses • Standard scratch-resistant coating • Oversized Lenses	Once per year	100% UCR 100% UCR 100% UCR
Eyeglass Frames • Eyeglass frames with a retail cost up to $250	Once per year	100% UCR
Contact Lenses • Covered Contact Lens Selection • Necessary Contact Lenses	Limited to a 12-month supply	100% UCR 100% UCR
Low Vision Services • Low Vision Testing • Low Vision Therapy	Once every 24 months	100% UCR 100% UCR

Pediatric Vision Benefits:

Benefits are provided for the following covered vision services and frequency as shown in the Schedule of Benefits for an Insured under age 26.

1. Routine Vision Examination or Refraction only in lieu of a complete exam
2. Eyeglass Lenses
   - Single Vision
   - Bifocal
   - Trifocal
   - Lenticular
3. Lens Extras
   - Polycarbonate Lenses
   - Standard scratch-resistant coating

- Oversized Lenses

4. Eyeglass Frames
   - Eyeglass frames with a retail cost up to $250
5. Contact Lenses
   - Covered Contact Lens Selection
   - Necessary Contact Lenses
6. Low Vision Services
   - Low Vision Testing
   - Low Vision Therapy

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.

Non-Insurance Assistance Services

Non-insurance Assistance services are provided by TSS Assist and not affiliated with Crum & Forster, SPC. An outline of the assistance services appears below.

Medical Emergency Services

- Worldwide, 24-hour medical location service
- Medical case monitoring, arrange communication between patient, family, physicians, employer, consulate, etc.
- Medical transportation arrangements –Emergency Evacuation/Repatriation/Return of Remains
- Emergency message service for medical situations

Legal Assistance

- Worldwide, 24-hour contact for non-criminal legal emergencies
- Legal referral to help you locate a consular official or attorney

Travel Assistance

- Help with lost passports, tickets and documents

TSS Assist

- U.S.: 1 (800) 730-2417
- E-mail for emergencies to assist@tssassist.com

Claim Procedures for Accident and Sickness, Dental, and Vision Benefits

In the event of Accident or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to the nearest Physician or Hospital.
2. Provide the ID card to the Physician or at the Hospital.
3. If there is an Injury or Accident, submit a Medical Accident Questionnaire to TSS.
4. In the event the provider does not submit the claim, secure a Company claim form from the Student Health Services or from the address below, fill out the form completely, attach all medical and hospital bills and statements and submit via one of the options below.
5. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit all Claims or Inquiries to:

Total Scholastic Solutions

Mail: TSS Administrative Services
PO Box 211008
Eagan, MN 55121
USA

Web: www.totalscholasticsolutions.com
E-mail: claimsassist@tssassist.com
Fax: 1-949-271-2330

Medical and Prescription Medication Claims

To file your claim, submit it online at www.totalscholasticsolutions.com. Log into the Member Area and select Submit Claim, and then follow the instructions to complete the online claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.

Right of Reimbursement / Subrogation

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to first reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

How You Can Reach Us

Customer Service, Pre-Authorization, and Help Locating a Provider (24/7)

Within the United States or Canada:	1-800-730-2417
Email:	assist@tssassist.com
Website:	www.totalscholasticsolutions.com

If you have questions, or in the event you remain dissatisfied and wish to make a complaint, you can do so by contacting the Plan Administrator at:

Clifford Allen Associates, Ltd.
PO Box 23615
Hilton Head Island, SC 29925
(888) 342-2224
info@shipsignup.com

Plan Underwriting Information

Plan is underwritten by Crum & Forster, SPC. C&F and Crum & Forster are registered trademarks of Crum & Forster, SPC. The Crum & Forster group of companies is rated A (Excellent) by AM Best Company 2024.

Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this Certificate 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 Certificate 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. For a detailed plan description, exclusions, and limitations please view the plan. 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.

THIS IS A LIMITED BENEFIT POLICY. The insurance described in this document provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

Complaints In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at 888-342-2224.

By purchasing this insurance provided by Crum & Forster SPC, under the jurisdiction of the Cayman Islands, you become a member of the Fairmont Specialty Trust.

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.

Please keep this brochure as a brief summary of the important features of the plan. It is not a contract of insurance. This plan includes both insurance and non-insurance benefits. The terms and conditions of the accident and sickness coverage are set forth in the policy. For a detailed plan description, exclusions, and limitations, please view the plan on file with your school or the Policy. The issued Policy contains a complete description of reductions, limitations, exclusions, definitions and termination provisions. If there is any conflict between this brochure and the Policy, the Policy shall govern in all cases.

Data Protection

Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.