



## ISM International K-12 Student Accident and Sickness Coverage Summary of Coverage and Enrollment Form 2018

The rates in the enrollment form are valid through December 31, 2018

Washington State

*This policy provides short term, limited duration insurance. It is not a major medical or comprehensive medical policy.*

**ism** Insurance  
Offered through ISM Insurance Inc., a subsidiary of ISM

Eligibility

CLASS OF ELIGIBLE PERSONS:

All students enrolled on a full-time basis while travelling outside of their home country and while participating in a foreign study program authorized by the policyholder.

When Coverage Begins

An Eligible Person will automatically become an Insured under the Policy at 12:01A.M. on the latest of the following dates:

1. The Policy Effective Date.
2. The date the person becomes a member of the Class of Eligible Persons.
3. The date the completed enrollment form, if any, is received by Us.
4. The date the required premium, if any, is paid to Us.

When Coverage Ends

Coverage for an Insured will end at 11:59 P.M. on the earliest of the following dates:

1. The date the Policy is terminated, or the end of the Policy Term, if earlier.
2. The Premium Due Date, if the required premium is not paid within 31 days of that date.
3. The date the person is no longer eligible.
4. The date the insured is no longer participating in a Covered Activity.

In the event an Insured enters the armed forces, unearned premium will be returned, but the amount returned will only be for the number of full months of the unexpired term of coverage, less any administrative fees.

If coverage ends it will not affect a claim for: (1) a covered Accident Death, Dismemberment or Paralysis; and Accidental Loss of Sight, Speech and Hearing, Loss due to a Covered Accident that occurred while coverage was in effect for the Insured; and (2) a covered expense due to an Injury occurring while coverage was in effect for the Insured, provided: (a) such expense was incurred while coverage was in effect for the Insured; and (b) treatment is rendered with 365 days of the Covered Accident.

Eligible Persons

Each person in the Class of Eligible Persons shown above is eligible to be insured on the Policy Effective Date, or the day after he or she becomes eligible, if later. We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover that the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

Covered Activities

Unless otherwise stated We will pay benefits for a Covered Loss only once, even if coverage may be provided under more than one Covered Activity. Coverage is in effect for an Insured only while he or she is participating in a Covered Activity.

Educational Travel

We will pay the benefits described in this brochure only if a Covered Person suffers a loss or incurs a Covered Expense as the direct result of a Covered Accident or Sickness while traveling:

1. outside of his or her Home Country and
2. engaging in a scheduled educational program sponsored by the Policyholder.

This coverage will start on the actual start of the trip. It does not matter whether the trip starts at the Covered Person's home or other place. Benefits will end on the earlier of the date the Covered Person returns home or the scheduled program ends.

Accidental Death and Dismemberment Benefit

1. Principal Sum: The Principal Sum which applies to each Insured is shown in the Schedule of Benefits.
2. Benefit Description:

If an injury to the insured results in any of the following losses within 365 days of an Accident, in accordance with the Covered Activity to which this benefit applies, We will pay the Benefit Amount shown opposite such loss in the Table of Benefits. The Principal Sum is shown on the Schedule of Benefits. If the Insured sustains more than one such loss as a result of any one Accident, We will pay only the one largest amount to which the Insured is entitled:

Table of Benefits	
Loss of Life.....	100%
Loss of Both Hands.....	100%
Loss of Both Feet.....	100%
Loss of Entire Sight of Both Eyes.....	100%
Loss of One Hand and One Foot.....	100%
Loss of One Hand and Entire Sight of One Eye.....	100%
Loss of One Foot and Entire Sight of One Eye.....	100%
Loss of Speech and Hearing in Both Ears.....	100%
Quadriplegia(total Paralysis of both upper and lower limbs)	100%
Paraplegia (total Paralysis of both lower limbs) .....	50%
Loss of One Hand.....	50%
Loss of One Foot.....	50%
Loss of Entire Sight of One Eye.....	50%
Loss of Speech.....	50%
Loss of Hearing in Both Ears .....	50%
Hemiplegia(total Paralysis of upper and lower limbs on one Side of body).....	50%
Loss of Thumb and Index Finger Same Hand .....	25%

"Loss of hand or foot" means complete Severance through or above the wrist or ankle joint. "Loss of Entire Sight" means the total, permanent loss of sight of the eye. The loss of sight must be unrecoverable by natural, surgical or artificial means. "Loss of Speech" means total and permanent loss of audible communication. "Loss of Hearing" means total and permanent loss of hearing. "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 the loss of use, without Severance, of a limb. This loss must be determined by a Physician to be complete and not reversible.

This benefit will be payable in addition to any other benefit payable under the Policy, subject to all terms and conditions of the Policy.

## Medical Evacuation Benefit

In the event an Insured requires Treatment as a result of a covered Injury or Sickness and an appropriate medical facility is not locally available for Medically Necessary Treatment, or if during Treatment at a local medical facility, the Insured's condition changes so that the local facility no longer can provide the Medically Necessary Treatment, the Insured may be evacuated to the nearest appropriate medical facility. Expenses for evacuation, accompanying Physician or Nurse, services and supplies which are directly Medically Necessary for evacuation, and fees necessary to arrange for the evacuation, are covered up to the Maximum Benefit amount shown in the Schedule of Benefits. The attending Physician must certify in writing that the evacuation is Medically Necessary. Any expenses with respect to the medical evacuation requires prior approval by Us. Initial air or ground ambulance to a medical facility are not included in this benefit.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider. The insured, or someone acting on behalf of the Insured, must contact the Administrator shown on the face page of the Policy and on file with the Policyholder.

## Accident Medical Expense Benefit

When Benefits are Payable: We will pay benefits for those Covered Expenses:

1. Incurred by the insured for Injury while insured under the Policy and in accordance with the Covered Activity to which this benefit applies
2. Provided the first such Covered Expense is incurred within 365 days after the date of the Accident first begins.
3. Covered Expenses must be incurred within 365 days after the first day of Treatment for the injury

We will extend coverage to expenses incurred within 104 weeks if an injury requires the removal of surgical pins, continued Treatment of serious burns or Treatment of non-union or mal-union of a fracture.

A Covered Expense will be deemed to have been incurred when the service, supply, or Treatment to which it relates is provided.

Amount of Benefits Payable: The amount of the benefit payable will be the eligible Covered Expenses incurred in excess of the Deductible amount (if any) shown on the Schedule of Benefits, subject to:

1. Any coinsurance rate applicable to such Covered Expense,
2. Any maximum amount payable for a specific Covered Expense; and
3. Any Maximum Benefit amount payable for all such Covered Expenses.

These amounts, if applicable, are as shown on the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of the Policy.

**Covered Expenses:** will be limited to the Usual, Customary and

Reasonable Charges incurred by the Insured for Medically Necessary care and Treatment, including:

1. Room and Board: a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. .
2. Intensive Care Unit expenses: the daily room rate when an Insured is confined in a Hospital in a bed in the Intensive Care Unit.

3. Hospital Miscellaneous services and supplies: a) while confined in a Hospital as an Inpatient; or b) as a precondition for being confined in a Hospital as an Inpatient. Eligible services and supplies include: the cost of an operating room; laboratory tests; X-ray expenses.(including reading charges); anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies
4. Inpatient Surgery: Physician's services for Inpatient surgery. Payment for surgery will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will be determined in accordance with the most current edition of the California Relative Value Study guidelines using the ICD9 procedure codes. Covered Expenses for Surgery will either be paid under this Inpatient surgery benefit or under the outpatient surgery benefit as is appropriate, but not both.
5. Inpatient Anesthesiologist Services: in connection with Inpatient surgery.
6. Inpatient registered Nurse's Services: a) private duty nursing care only; b) while confined in a Hospital as an Inpatient; c) ordered by a licensed Physician; and d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
7. Inpatient Physician's Visits: when confined in a Hospital as an Inpatient, eligible services are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians' visits will be paid under this Inpatient Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.
8. Outpatient Surgery: Physician's services for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will be determined in accordance with the most current edition of the California Relative Value Study guidelines using the ICD9 procedure codes. Covered expenses for surgery will either be paid under this outpatient benefit or under the Inpatient surgery benefit as appropriate, but not both.
9. Scheduled Outpatient Surgery Miscellaneous: in connection with scheduled outpatient surgery. Eligible services and supplies include: the cost of the operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a hospital, an Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.
10. Assistant Surgeon expenses when attendance by an assistance surgeon is Medically Necessary.
11. Outpatient Anesthesiologist Services: in connection with scheduled outpatient surgery.
12. Outpatient Physician Visits: eligible services are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy/chiropractic services.
13. Outpatient Braces and Appliances: a) when prescribed by a Physician; and b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable medical equipment, which is equipment, that: a) is primarily and customarily used to service a medical purpose; b) can withstand repeated use; and c) generally is not useful to the person in the absence of injury. No benefits will be paid for rental charges in excess of purchase price.
14. Outpatient Physiotherapy/Acupuncture/Chiropractic Services: Service must be prescribed by a licenses Physician, and such prescription is for a stated number of visits.
15. Outpatient Medical Emergency: use of the emergency room and supplies.
16. Outpatient Diagnostic X-ray Services: Diagnostic X-rays are only those procedures identified on Physicians' Current Procedural Terminology (CPT) as codes 70000-79999 inclusive. X-ray reading expenses are covered.
17. Outpatient Laboratory Tests and Procedures.
18. Outpatient Prescription Drugs, including Medically Necessary equipment and supplies, as prescribed by a health care provider for diabetes, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications

associated with diabetes, and glucagon emergency kits; and outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes.

19. Professional Ground Ambulance Services: From the site of an emergency to the Hospital.
20. Dental Treatment: a) when performed by a Physician and b) made necessary by injury to sound, natural teeth.
21. Repair or Replacement of Broken Eyeglasses, frames or lenses as a result of a Covered Accident for which the Insured received Medically Necessary Treatment or services.
22. Outpatient Diagnostic Imaging: diagnostic services and medical procedures when performed by a Physician (unless otherwise covered under Physician's visits; physiotherapy/chiropractic services; X-rays; and laboratory procedures).

## Sickness Medical Expense Benefit

When Benefits are Payable: We will pay benefits for those Covered Expenses:

1. Incurred by the insured for Sickness while insured under the Policy,
2. Provided the first such Covered Expense is incurred within 365 days after the date of the Sickness first begins.
3. Covered Expenses must be incurred within 365 days after the first day of Treatment for the Sickness

A Covered Expense will be deemed to have been incurred when the service, supply, or Treatment to which it relates is provided.

Amount of Benefits Payable: The amount of the benefit payable will be the eligible Covered Expenses incurred in excess of the Deductible amount (if any) shown on the Schedule of Benefits, subject to:

1. Any coinsurance rate applicable to such Covered Expense,
2. Any maximum amount payable for a specific Covered Expense; and
3. Any Maximum Benefit amount payable for all such Covered Expenses.

These amounts, if applicable, are as shown on the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of the Policy.

## Covered Expenses:

will be limited to the Usual, Customary and Reasonable Charges incurred by the Insured for Medically Necessary care and Treatment, including:

1. Room and Board: a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2. Daily Intensive Care Unit expenses: the daily room rate when an Insured is hospital confined in a bed in the intensive care unit and nursing services other than private duty nursing services.
3. Hospital Miscellaneous Charges: services and supplies: a) while confined in a Hospital as an Inpatient; or b) as a precondition for being confined in a Hospital as an Inpatient. Eligible services and supplies include: the cost of an operating room; laboratory tests; X-ray expenses (including reading charges); anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
4. Inpatient Surgery: Physician's services for Inpatient surgery. Payment for surgery will be made based upon surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession as the same operative session, the maximum amount paid will be determined in accordance with the most current edition of the California Relative Value Study guidelines using the ICD9 procedure codes. Covered Expenses for surgery will either be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, as appropriate, but not both.
5. Assistant Surgeon Expenses when Medically Necessary.
6. Inpatient Anesthesiologist Services: in connection with Inpatient surgery.

7. Inpatient Registered Nurse's Services: a) private duty nursing care only; b) while confined in a Hospital as an Inpatient; c) ordered by a licensed Physician; and d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
8. Inpatient Physician's Visits: when confined in a Hospital as an Inpatient, eligible services are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians' visits will be paid under this Inpatient Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.
9. Outpatient Surgery: Physician's services for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession as the same operative session, the maximum amount paid will be determined in accordance with the most current edition of the California Relative Value Study guidelines using the ICD9 procedure codes. Covered Expenses for surgery will either be paid under this outpatient surgery benefit or under the Inpatient surgery benefit, as appropriate, but not both.
10. Scheduled Outpatient Surgery Miscellaneous: in connection with scheduled outpatient surgery. Eligible services and supplies include: the cost of the operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a Hospital, and Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.
11. Outpatient Anesthesiologist Services: in connection with scheduled outpatient surgery.
12. Outpatient Physician's visits: eligible services are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy/chiropractic services.
13. Outpatient Braces and Appliances: a) when prescribed by a Physician; and b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable medical equipment, which is equipment, that: a) is primarily and customarily used to serve a medical purpose; b) can withstand repeated use; and c) generally is not useful to the person in the absence of injury. No benefits will be paid for rental charges in excess of purchase price.
14. Outpatient Physiotherapy/Chiropractic Services: Service must be prescribed by a licensed Physician, and such prescription is for a stated number of visits.
15. Outpatient Medical Emergency: use of the emergency room and supplies.
16. Outpatient Diagnostic X-ray Services: Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 – 79999 inclusive. X-ray readings are covered.
17. Outpatient Laboratory Tests and Procedures.
18. Outpatient Chemotherapy, including prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility.
19. Outpatient Prescription Drugs, including Medically Necessary equipment and supplies, as prescribed by a health care provider for diabetes, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes.
20. Professional Ground Ambulance Services: From the site of an emergency to the Hospital.
21. Outpatient Diagnostic Imaging: diagnostic services and medical procedures when performed by a Physician (unless otherwise payable under Physician's visits; physiotherapy/chiropractic services; X-rays; and laboratory procedures).
22. Wellness Benefits:
  - Routine physical exam
  - Pediatric dental care (exam, cleaning, fluoride treatment)
  - Pediatric vision care (exam, frames)

- Immunizations vaccines: Diphtheria, Tetanus, Pertussis; Haemophilus influenza type b; Hepatitis A; Hepatitis B, Human Papillomavirus; Inactivated Poliovirus; Influenza (Flu Shot); Measles; Meningococcal; Pneumococcal; Rotavirus; Varicella.
- Alcohol, drug use, and behavioral assessments
- Blood pressure screening; Depression screening

## Remains Repatriation Benefit

If the Insured dies while outside his or her Home Country, We will pay the actual charges for preparing and transporting the Insured's remains to his or her Home Country. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to the Insured's home.

The death must occur while the person is insured for this benefit. The Maximum Benefit Amount is shown in the Schedule of Benefits. This provision is subject to all of the terms of the Policy.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by our assistance provider. The Insured, or someone acting on behalf of the Insured, must contact the Administrator shown on the face page of the Policy, and on file with the Policyholder.

## Emergency Reunion Benefit

We will pay benefit shown in the Schedule of Benefits, if the Insured is hospitalized for at least seven (7) days due to an Accident or Sickness. The benefit will be provided for round trip airfare (tourist class) expenses to the host country for a member of the Insured's immediate Family and their hotels and meals.

In the event of death, or life-threatening Accident or illness of a member of the Insured's Immediate Family, requiring the Insured to return home after arriving at their placement, We will arrange, and pay for their returning airfare (tourist class) from the host country to their Home Country point of departure. Both Us and the Administrator must be advised and approve the flight which must be arranged through the Administrator. Retroactive claims will not be accepted.

Benefits will not be payable unless We authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider. The Insured, or someone acting on behalf of the Insured, must contact the Administrator shown on the face page of the Policy, and on file with the Policyholder.

## Home Health Care Expense Benefit

The Company will pay Covered Expenses incurred for care and treatment rendered to the Insured by a Home Health Care Agency for the following Home Health Care Services:

1. Part-time nursing care furnished by or under the supervision of a registered graduate nurse (RN);
2. Part-time Home Health Aide services which consists mainly in caring for the patient;
3. Physical therapy, occupational therapy, speech therapy and respiratory and inhalation therapy;
4. Nutrition counseling by a nutritionist or dietician;
5. Medical social service by a qualified social worker licensed by the jurisdiction in which services are rendered; and
6. Medical supplies, prosthetic and orthopedic appliances, rental or purchase of durable medical equipment, drugs and medicines obtainable by prescription only, including insulin, but only to the extent that such expenses would have been considered Covered Expenses had the Insured required confinement in a Hospital or skilled nursing facility.

Benefits will be payable for up to 130 Home Health Care visits per Policy Term. Each visit by a Home Health Care Agency employee constitutes a Home Health Care visit and each four hours of Home Health Aide services constitutes a Home Health Care visit.

Expenses under any other benefit will not be covered under this Home Health Care Expense Benefit.

Benefits are subject to the Deductible and Coinsurance Rate (if any) shown in the Schedule of Benefits.

Covered Expenses for Home Health Care services and supplies does not include:

1. Charges for services by a person who usually resides in the Insured's home or is the spouse or a member of the Insured's family.
2. Charges incurred while the Insured is not under the care of a Physician.
3. Charges in excess of the Usual and Customary charges or charges for unnecessary care or treatment. Also, no payment will be made for expenses incurred for or in connection with custodial care, education or training.
4. Charges for services or supplies not specified in the Home Health Care Plan.

Daily Living Services means cooking, feeding bathing, dressing and personal hygiene services performed by a Home Health Aide which are necessary to the care and health of the Insured.

Home Health Aide means a person who:

1. Provides care of a medical or therapeutic nature, or who provides Daily Living Services; and
2. Reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care means nursing care and treatment and Daily Living Services provided to the Insured in His home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. The Home Health Care plan must be established and approved in writing by the Insured's attending Physician, including certification in writing by the attending Physician that confinement in a Hospital or extended care facility would be required in the absence of Home Health Care;
2. Nursing care and treatment must be provided by a Hospital certified to provide Home Health Care Services or by a certified Home Health Care Agency; and
3. Daily Living Services must be approved in writing by the attending Physician or by the provider of the nursing care services.

Home Health Care Agency means is an agency which:

1. Is constituted, licensed and operated under the provision of Title XVIII for the Federal Social Security Act, as amended, and certified by the jurisdiction in which the Home Health Care plan is established;
2. Is engaged primarily in providing extended care facility services and other therapeutic services under the supervision of a Physician or a registered graduate nurse; and
3. Maintains clinical records on all patients.

## Hospice Care Expense Benefit

We will pay expenses incurred within a Benefit Period for services and supplies provided as part of a Hospice Care Program. Benefits will be provided on the same basis as a covered Sickness when the attending Physician certifies that: (a) the Insured is terminally ill and has a life expectancy of six months or less; and (b) Hospice Care is Medically Necessary. The Company may require a copy of the Insured's plan of care and any changes made to the level of care or plan of care.

Covered services are as follows:

1. Inpatient Hospice Services while confined in a Hospice Facility or Hospital for up to six months;
2. Home care and outpatient services under a Hospice Care Program, including drugs and medical supplies; and
3. Bereavement counseling services for: the Insured's family within one year after such person's death, up to five counseling sessions. Inpatient care will be extended for up to an additional six months if the Insured is

facing imminent death or is entering remission and his condition has been certified in writing, by the attending Physician.

Expenses under any other benefit will not be covered under this Hospice Care Expense Benefit.

Services and expenses incurred in connection with an unrelated covered Sickness will be paid in accordance with the Policy provisions that apply to other covered Sicknesses and covered Injuries.

Hospice Facility means an institution or part of an institution which is:

1. Primarily engaged in providing care for terminally ill patients;
2. Accredited by the National Hospice Organization; and
3. Approved by us as meeting established standards, including any licensing requirement of the state or locality in which it operates.

Hospice Care Program is a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual and social needs of dying individuals and their families, by providing palliative and supportive medical, nursing and other health services through home or inpatient care during the illness and bereavement. The program is provided to individuals who have no reasonable prospect of cure and, as estimated by a Physician, have a life expectancy of not more than 6 months, and to the families of those individuals. Benefit payments will be subject to the Deductible, Coinsurance Rate, Benefit Maximum, and Benefit Period (if any) shown in the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of the policy.

## MANDATED BENEFITS

### Mental and Nervous Conditions Expense Benefit

We will pay Covered Expenses incurred for Medically Necessary Treatment of mental disease or disorder and emotional disorder or functional nervous disorder as classified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, if Treatment is rendered by:

1. A licensed Physician;
2. A licensed psychologist or psychiatrist;
3. A community mental health agency licensed under state law, provided such agency has in effect a plan for quality assurance and peer review and the Insured's Treatment is supervised by a Physician or a licensed psychologist or psychiatrist; or
4. A Hospital, including a state hospital

Covered Expenses are subject to the limitations described below:

1. For Hospital Inpatient Treatment, We will pay benefits on the same basis as any other covered Sickness; and
2. For outpatient Treatment, Covered Expenses will be limited to the amount shown in the Schedule of Benefits, per visit. Such limited expenses will be paid after the Insured satisfies the Deductible, up to a Maximum Benefit, per Policy Term; and
3. Subject to an Aggregate Benefit Maximum for Mental and Nervous Conditions for all Inpatient and Outpatient Treatment in any Policy Term.

The Deductible, Coinsurance Rate, Maximum Benefit are shown in the Schedule of Benefits.

### Diabetes Medical Expense Benefit

We will pay Covered Expenses incurred for Treatment of diabetes, including pharmacy services, as appropriate and Medically Necessary equipment, and supplies, as prescribed by a Physician, including but not limited to:

1. Insulin;
2. Syringes;
3. Injection aids;
4. Blood glucose monitors;

5. Test strips for blood glucose monitors;
6. Visual reading and urine test strips
7. Insulin pumps and accessories to the pumps;
8. Insulin infusion devices;
9. Prescriptive oral agents for controlling blood sugar levels;
10. Foot care appliances for prevention of complications associated with diabetes; and
11. Glucagon emergency kits; and
12. Outpatient self-management training and education, including medical nutrition therapy. Coverage will be provided only when such outpatient self-management training and education is rendered by a Physician with expertise in the Treatment of diabetes.

Covered Expenses will be provided on the same basis as any other covered Sickness.

Benefit payments will be subject to Deductible, Co-insurance Rate, Maximum Benefit, and Benefit Period (if any) shown in the Schedule of Benefits.

## LIMITATIONS

### Pre-existing Condition Limitation

This Rider does not provide coverage for a Pre-existing Condition until the Insured has been covered under this Rider for three months. This limitation does not apply to pregnancy, and coverage provided to newborn and adopted children.

However, if an Insured has Covered Expenses which would otherwise be excluded by this Pre-existing Condition Limitation, and if:

1. The Insured had Qualifying Coverage under a substantially similar plan within three months prior to the date of application for coverage under this Rider; and
2. The prior plan covered the Pre-existing Condition,

THEN, the three-month period of exclusion from coverage of such Pre-existing Condition will be reduced by the period of such Qualifying Coverage.

"Pre-existing Condition" means any sickness for which the Insured received medical advice or treatment, or treatment was recommended, or the Insured took prescribed medicine within three months before the effective date of the Insured's coverage under this Rider.

"Qualifying Coverage" means any health coverage providing coverage similar to the coverage provided under this Rider, including an employer provided self-funded health plan.

"Credit for Prior Coverage" – An insured, whose coverage under prior Creditable Coverage ended no more than 100 days before coverage under this Rider became effective, will have any applicable Pre-existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 100 days, We will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

1. Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
2. The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
3. The Medicaid program pursuant to Title XIX of the Social Security Act,

other than coverage consisting solely of benefits under section 1928;

4. Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
5. A medical care program of the Indian Health Service or of a tribal organization;
6. A state health benefits risk pool;
7. A health plan offered under Chapter 89 of Title 5, United States Code, the Federal Employee's Health Benefits Program;
8. A public health plan as defined by federal regulations; or
9. A health benefit plan under section 5 (e) of the Peace Corps Act.

## SUBROGATION PROVISION

We may recover any benefits paid under the Policy to the extent an Insured is paid for the same Injury by a third party, or another insurer. We may only be reimbursed to the amount of the Insured's recovery. A refund from any recovery will only be made to Us from the amount of the recovery that exceeds the amount necessary for the Insured to be Made Whole. "Made whole" means that the Insured has been fully compensated for all damages, including any award for loss of employment and paid and suffering. Further, We have the right to offset future benefits payable to the Insured under the Policy against such recovery.

Upon request the Insured must complete the required forms and return them to Us or Our authorized producer. The Insured must cooperate fully with Us or Our representative in asserting its right to recover.

# 2018 INTERNATIONAL STUDENT ACCIDENT AND SICKNESS INSURANCE

## SCHEDULE OF BENEFITS

	<b>Bronze Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.	<b>Silver Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.	<b>Gold Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.
ACCIDENT MEDICAL EXPENSE			
Maximum Benefit (per occurrence)	\$250,000	\$250,000	\$500,000
Maximum Benefit (per occurrence) for Interscholastic Sports:	\$10,000	\$10,000	\$10,000
Deductible (per policy term)	\$200	\$0	\$0
Coinsurance*	80% of UC&R up to \$5,000 then 100% of UC&R*	100% of UC&R*	100% of UC&R*
<u>Inpatient:</u>			
Room & Board	80% of UC&R	100% of UC&R	100% of UC&R
Intensive Care Unit (ICU)	80% of UC&R	100% of UC&R	100% of UC&R
Hospital Miscellaneous Charges	80% of UC&R	100% of UC&R	100% of UC&R
Surgery	80% of UC&R	100% of UC&R	100% of UC&R
Assistant Surgeon	80% of UC&R	100% of UC&R	100% of UC&R
Anesthesiologist	80% of UC&R	100% of UC&R	100% of UC&R
Physician Visits	80% of UC&R	100% of UC&R	100% of UC&R
<u>Outpatient</u>			
Surgery	80% of UC&R	100% of UC&R	100% of UC&R
Surgery Miscellaneous	80% of UC&R	100% of UC&R	100% of UC&R
Assistant Surgeon	80% of UC&R	100% of UC&R	100% of UC&R
Anesthesiologist	80% of UC&R	100% of UC&R	100% of UC&R
Physician Visits	80% of UC&R	100% of UC&R	100% of UC&R
Braces and Appliances	80% of UC&R	100% of UC&R	100% of UC&R
Chiropractic Services	\$50 per visit to a maximum benefit of \$1,000 per policy term	\$50 per visit to a maximum benefit of \$1,000 per policy term	\$50 per visit to a maximum benefit of \$1,000 per policy term
Physiotherapy/Acupuncture	\$2,500	\$2,500	\$2,500
Medical Emergency	80% of UC&R	100% of UC&R	100% of UC&R
Diagnostic X-rays	80% of UC&R	100% of UC&R	100% of UC&R
Laboratory Tests and Procedures	80% of UC&R	100% of UC&R	100% of UC&R
Prescription Drugs	50% of UC&R	50% of UC&R	50% of UC&R
<u>Other</u>			
Ambulance	\$750	\$750	\$750
Dental	\$200 per tooth \$500 per injury	\$200 per tooth \$500 per injury	\$200 per tooth \$500 per injury

## 2018 INTERNATIONAL STUDENT ACCIDENT AND SICKNESS INSURANCE

	<b>Bronze Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.	<b>Silver Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.	<b>Gold Plan</b> All percentages specified below are based on the Usual & Customary Charges (U&C) incurred, except as stated otherwise.
Eyeglass Replacement	\$25 per year	\$25 per year	\$25 per year
Diagnostic Imaging (MRI, CT Scan)	80% of UC&R	100% of UC&R	100% of UC&R
<b>ACCIDENTAL DEATH AND DISMEMBERMENT</b>	\$10,000	\$10,000	\$10,000
<b>DIABETES MEDICAL EXPENSE</b>	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness
<b>EMERGENCY REUNION</b>	\$1,000	\$1,000	\$1,000
<b>HOME HEALTH CARE BENEFIT</b>			
Maximum Benefit Amount	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness
Maximum Benefit	130 visits	130 visits	130 visits
Coinsurance	100% of UC&R*	100% of UC&R*	100% of UC&R*
<b>HOSPICE CARE EXPENSE BENEFIT</b>			
Maximum Benefit Amount	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness
Maximum Benefit	12 months	12 months	12 months
Coinsurance*	100% of UC&R*	100% of UC&R*	100% of UC&R*
<b>MEDICAL EVACUATION</b>	100% of covered expenses	100% of covered expenses	100% of covered expenses
<b>MENTAL AND NERVOUS CONDITIONS EXPENSE</b>	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness	Paid the same as any other covered Sickness
<b>REMAINS REPATRIATION</b>	100% of covered expenses	100% of covered expenses	100% of covered expenses
<b>SICKNESS MEDICAL EXPENSE</b>			
Maximum Benefit (per occurrence)	\$250,000	\$250,000	\$500,000
Deductible (per policy term)	\$200	\$0	\$0
Coinsurance*	80% of UC&R* up to \$5,000 then 100% of UC&R	100% of UC&R*	100% of UC&R*
<b>Inpatient</b>			
Room & Board	80% of UC&R	100% of UC&R	100% of UC&R
Intensive Care Unit (ICU)	80% of UC&R	100% of UC&R	100% of UC&R
Hospital Miscellaneous Charges	80% of UC&R	100% of UC&R	100% of UC&R
Surgery	80% of UC&R	100% of UC&R	100% of UC&R
Assistant Surgeon	80% of UC&R	100% of UC&R	100% of UC&R

## 2018 INTERNATIONAL STUDENT ACCIDENT AND SICKNESS INSURANCE

Anesthesiologist	80% of UC&R	100% of UC&R	100% of UC&R
Physician Visits	80% of UC&R	100% of UC&R	100% of UC&R
<u>Outpatient</u>			
Surgery	80% of UC&R	100% of UC&R	100% of UC&R
Surgery Miscellaneous	80% of UC&R	100% of UC&R	100% of UC&R
Assistant Surgeon	80% of UC&R	100% of UC&R	100% of UC&R
Anesthesiologist	80% of UC&R	100% of UC&R	100% of UC&R
Physician Visits	80% of UC&R	100% of UC&R	100% of UC&R
Braces and Appliances	80% of UC&R	100% of UC&R	100% of UC&R
Chiropractic Services	\$50 per visit to a maximum benefit of \$1,000 per policy term	\$50 per visit to a maximum benefit of \$1,000 per policy term	\$50 per visit to a maximum benefit of \$1,000 per policy term
Physiotherapy/Acupuncture	\$2,500	\$2,500	\$2,500
Medical Emergency	80% of UC&R	100% of UC&R	100% of UC&R
Diagnostic X-rays	80% of UC&R	100% of UC&R	100% of UC&R
Laboratory Tests and Procedures	80% of UC&R	100% of UC&R	100% of UC&R
Prescription Drugs	100% of UC&R up to a maximum benefit of \$2,000	100% of UC&R up to a maximum benefit of \$2,000	100% of UC&R up to a maximum benefit of \$2,000
Wellness Benefits	100% of UC&R	100% of UC&R	100% of UC&R
<u>Other</u>			
Ambulance	\$750	\$750	\$750
Dental	\$200 per tooth \$500 per injury	\$200 per tooth \$500 per injury	\$200 per tooth \$500 per injury
Diagnostic Imaging (MRI, CT Scan)	80% of UC&R	100% of UC&R	100% of UC&R
Diabetes Medical Expense Benefit	80% of UC&R	100% of UC&R	100% of UC&R

\*Percentage is based on Usual, Customary and Reasonable Charges incurred by the Insured.

All inquires should be directed to ismincinsurance Inc. at intl@isminc.com, or 302-656-4944

## General Exclusions

We will not pay benefits for any loss or Injury that is caused by or results from:

1. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment.
2. War or any act of war, declared or undeclared
3. Commission of or active participation in a riot or insurrection; fighting or brawling, except in self-defense; commission of or attempt to commit a felony; or other illegal activity.
4. Suicide, attempted suicide or intentionally self-inflicted injury.
5. Treatment by persons employed or retained by a School, or by any Immediate Family or member of the Insured's household; or covered medical expenses for which the Insured would not be responsible for in the absence of the policy.
6. Injury covered by Worker's Compensation, Employer's Liability Laws, or similar occupational benefits; expenses payable by any automobile insurance policy without regard to fault.
7. Dental care or Treatment. This exclusion does not apply to care of sound, natural teeth and gums resulting from an Accident while the insured is insured under the Policy.
8. Flight in any type of aircraft, except while riding as a fare-paying passenger on a regularly-scheduled airline.
9. Cosmetic surgery, except cosmetic surgery which the Insured needs as the result of an Accident which happens while the person is the Insured under the Policy.
10. Routine physical examinations and routine testing; preventative testing or Treatment; screening examinations or testing in the absence of Injury.

In addition to the Exclusions above, the following exclusions may also apply to the Sickness Medical Expense Benefit:

1. Benefits are not payable for a Sickness that is a "Pre-existing Condition" (a condition for which the Insured received medical treatment, care or advice within 3 months before being insured under the policy). But this exclusion does not apply after the Insured has been insured under the Policy for 3 straight months or was insured under prior creditable coverage.
2. Elective Treatments and voluntary testing.
3. Pregnancy, normal maternity, C-section, and miscarriage, or any complications resulting from any of these.

## Definitions

**ACCIDENT**—means a sudden, unexpected and unintended incident. "Covered Accident" means an Accident that results in Injury or loss covered by the Policy.

**CALIFORNIA RELATIVE VALUE STUDY** – means a numeric coding system for all diagnostic and therapeutic procedures performed by or directly under the supervision of a Physician; the system is used by Physicians to determine a procedure's level of difficulty, which in part determines the fee.

**COVERED LOSS OR COVERED LOSSES**—means a Sickness or an accidental death, dismemberment or other loss resulting from Injury covered under the Policy.

**HOME COUNTRY**—means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country that the Covered Person has declared to Us in writing as his or her Home Country.

**HOSPITAL**—means a legally constituted institution that: (a) has organized facilities for the care and Treatment of sick or injured persons on a registered Inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed Physicians; and (b) provides 24-hour nursing service by registered Nurses (R.N.) on duty. Also, Hospital means a licensed rehabilitation and detoxification facility for chemical dependency or a mental hospital. Rehabilitation and detoxification facilities for chemical dependency and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

It is not a facility that is 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 is not a place for the aged.

**IMMEDIATE FAMILY**—means an Insured's parent, grandparent, brother, sister, legal guardian, or anyone else related by blood or marriage.

**INJURY**—means accidental bodily harm sustained by the Insured that results directly from an Accident (independently of all other causes) and occurs while coverage under the Policy is in force. The Injury must be caused solely through accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury

**INPATIENT**. —means confinement in a Hospital for which the Insured is charged at least one full day's room and board.

**INSURED**—means an eligible person who makes application for, or for whom application is made and who is approved to participate in the benefit plans issued under the Policy, provided the required premium for such person's insurance is paid when due.

**MEDICALLY NECESSARY** or **MEDICAL NECESSITY**—means the services or supplies provided by a Hospital, Physician, or other provider that are required to identify or treat an Injury or Sickness and that, as determined by Us, are: (1) consistent with the symptom or diagnosis and Treatment of Injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Insured; and (4) the most appropriate supply or level of service that can be safely provided. When applied to the care of an Inpatient, it further means that the Insured's medical symptoms or condition requires that the services cannot be safely provided as an Outpatient.

**NURSE**—means a person who has been registered or licensed to practice by the State Board of Nurse Examiners or other state authority in the state where the person works, and who is practicing within the scope and limitation of that license. The term Nurse will not include the Insured or the Insured's brothers, sisters, or parents, or any other person residing in the Insured's household.

**OUTPATIENT SURGICAL FACILITY**—means a surgical or medical center, that has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Nurses; and (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under that law.

**PHYSICIAN**—means a practitioner of the healing arts who is duly licensed and who is treating within the scope and limitation of that license. The term Physician will not include the Insured or the Insured's brothers, sisters, or parents, or any other person residing in the Insured's household.

**SCHOOL**—means any facility under the management of the Policyholder which operates for the purpose of educating its students.

**SICKNESS**—means illness or disease contracted by and causing loss to the Insured whose Sickness is the basis of claim. Any complications or any condition arising out of a Sickness for which the Insured is being treated or has received Treatment will be considered as part of the original Sickness. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

**TREATMENT**—means a specific in-office or Hospital physical examinations of, or care rendered to, the Insured.

**USUAL CUSTOMARY AND REASONABLE CHARGE(S)**—"Usual" means those charges made by a provider for services and supplies rendered to all patients for the same or similar Injury or Sickness. "Customary" means those charges made by the majority of providers in the area for the same or similar services or supplies. "Reasonable" means those charges that do not exceed the majority of the prevailing fees in the area for the same or similar services or supplies. "Area" means a county or larger geographically significant area as determined by Us.

**WE, OUR, US**—means the insurance company underwriting this insurance or its authorized agent.

Please Read Before Completing Enrollment Form

o Policy Form Number: AH 40537 – P/C 273220 – GEN o

Telephone: 1-800-715-7261

This telephone number is intended for package delivery purposes only. All inquiries should be directed to ISM.

Online: www.isminc.com/insurance

Please make check or Money Order payable to:  
ACE American Insurance Company  
Please send payment in U.S. Dollars

Please mail all enrollment forms, checks, Money Orders, and  
Credit Card payments to:  
U.S. Mail  
ACE American Insurance Company  
c/o Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802

K-12 School Information

Name of School \_\_\_\_\_  
 School Mailing Address \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Student Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Home Address \_\_\_\_\_ City \_\_\_\_\_  
 Providence \_\_\_\_\_ Postal Code \_\_\_\_\_ Home Country \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Type of Visa Held  F-1  J-1  Other (Specify) \_\_\_\_\_  
 Beneficiary/Relationship \_\_\_\_\_

Coverage will begin on the latest of the following:

- a) the Policy Effective Date, or b) the date We receive the completed enrollment form, or c) the date the required premium is paid, or d) your scheduled Trip departure date.

Have you insured with us before?  Yes  No Accidental Death Benefit \_\_\_\_\_

I want my Insurance to begin on \_\_\_\_/\_\_\_\_/\_\_\_\_ and continue for \_\_\_\_\_ months\*.

\*You may enroll for up to 12 consecutive months.

Plan Rates:  Bronze \$95.00/month  Silver \$129.00/month  Gold \$158.00/month

\*Add 2% non-refundable administrative fee to all packages. Please see example for more information.

Method of Payment:  Check  Money Order  MasterCard  Visa Card

We do not accept Discover Card or American Express

\_\_\_\_\_ x \_\_\_\_\_ Months = \$ \_\_\_\_\_ USD \_\_\_\_\_ x 2%\* = \_\_\_\_\_ USD  
 Rate Months Total Premium Total Premium

I authorize ACE to bill my account for the total amount of \$ \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_ USD

Total Premium Admin Fee Amount Due

Card# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Security Code \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

*I understand that benefits may not be payable for conditions existing prior to the effective date of coverage (see definition of 'Pre-existing Condition'). My signature below certifies that I have read and understand the International Student Accident and Sickness Insurance Plan brochure and agree to accept it as applicable to me, the terms and conditions stated therein. 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 the claim was provided by the applicant.*

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## Claims Administrator:

Administrative Concepts, Inc. (ACI), 994 Old Eagle School Rd., Suite 1005, Wayne, PA 19087-1706. From within the USA and Canada: 1-800-715-7261 \* Outside the USA or Canada call: 1-610-293-9229\* Fax: 1-610-293-9299 \* Web: [www.visit-aci.com](http://www.visit-aci.com)

## Emergency Assistance: EuropAssistance USA

In addition to this insurance program is access to the 24-hour Assistance network for emergency assistance anywhere in the world. Simply call the assistance center at EuropAssistance USA toll-free, direct, or collect using the telephone numbers listed below. The multilingual staff will answer your call and provide reliable, professional and thorough assistance. The following services are included in the program: referral to the nearest, most appropriate medical facility and/or provider; medical monitoring by board-certified emergency doctors in the United States; urgent message relay between family, friends, personal doctor, school, and insured; guarantee of payment to provider and assistance in coordinating insurance benefits; arranging and coordinating Emergency Medical Evacuations, and Repatriations of Remains; Emergency travel arrangements for disrupted travel as the consequence of a medical emergency; referral to legal assistance; assistance in locating lost or stolen items including lost ticket application processing.

For medical evacuation, repatriation or other assistance services call: EuropAssistance USA at 1-800-243-6124 (inside the U.S.) or call collect 1-202-659-7803 (from outside the U.S.) or e-mail [ops@europassistance-usa.com](mailto:ops@europassistance-usa.com). When you call, please be prepared with the following information: 1) name of caller, phone #, fax #, and relationship to insured; 2) insured's name, age, sex and the policy number for Your insurance plan, and Your Plan Number (01AH585); 3) a description of the insured's condition; 4) name, location and telephone number of the hospital or other service provider; and 5) other insurance information including health insurance, worker's compensation, or auto insurance if the insured was involved in an accident.

## Important Notice:

This policy provides travel insurance benefits for individuals traveling outside of their home country. This policy does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy a person's individual obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

For more information about the ACA, please refer to [www.HealthCare.gov](http://www.HealthCare.gov).

## Express Scripts Prescription Drug

You are not required to fill your prescriptions at an Express Scripts Participating Pharmacy. However, if you do, your out-of-pocket expenses may be less. Prescriptions can be filled at an Express Scripts Participating Pharmacy. Covered persons must show their insurance identification card to the Pharmacy as proof of coverage. Your group number and identification number is on your ID Card. No claim forms are necessary for prescriptions. A listing of the contracted pharmacies and services is available at Express Scripts website [www.express-scripts.com](http://www.express-scripts.com) or you may contact customer services at 1-800-400-0136.

## Preferred Provider Information

Preferred Providers allow the Covered Person to maximize the benefits offered under the Plan. A Preferred Provider Organization consists of hospitals, doctors, ancillary and other health care providers organized into a Network for the purpose of delivering quality health care at affordable rates. You are not required to utilize the services of the Network Provider. However, if you do, your out-of-pocket expenses may be less.

The Preferred Provider Organization is MultiPlan. For a list of providers, please go to [www.multiplan.com](http://www.multiplan.com), or call (800) 672-2140.

This Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the Policyholder on Form #AH-40537. The Policy is subject to the laws of the state in which it is issued. Coverage may not be available in all states or certain terms and conditions may be different if required by state law. Please keep this information as a reference.

Marketed by:

**ism** Insurance

*Offered through ISM Insurance Inc., a subsidiary of ISM*

1316 North Union Street  
Wilmington, DE 19806-2594

Questions, please contact  
Phone: 302-656-4944  
E-mail: [intl@isminc.com](mailto:intl@isminc.com)  
Web: [isminc.com](http://isminc.com)

ENROLL ONLINE: [www.isminc.com](http://www.isminc.com)

Please mail all enrollment forms, checks, Money Orders, and Credit Card payments to:

ACE American Insurance Company  
c/o Administrative Concepts, Inc.  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802

**CHUBB**

Chubb NA is the U.S.-based operating division of the Chubb Group of Companies, headed by Chubb Ltd. (NYSE:CB) Insurance products and services are provided by Chubb Insurance underwriting companies and not by the parent company itself.