



TRAWICK  
INTERNATIONAL

**ACCIDENT & SICKNESS INSURANCE PLAN**  
Designed Especially for the  
International Students of

**Arkansas State University**  
**Jonesboro, AR**  
**2013-2014**

**Underwritten By:**  
**United States Fire Insurance Company**  
Eatontown, New Jersey

**Policy # US100825**

**OUR PRIVACY POLICY:** *We know your privacy is important to you. We strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law including HIPPA. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information.*

**Schedule of Benefits**

**\$300,000 per Maximum per Accident/Sickness per Policy Year**

**\$50 Deductible per Policy Year**

**After the Deductible the plan pays 100% of Usual, Reasonable and Customary Charge (URC)**

**Benefit Period - 1 year from the date of the Covered Accident or Sickness**

<b>Description of Service</b>	<b>After the Deductible</b>	<b>Limitations</b>
Room & Board (including Intensive Care)	100%	Of the Negotiated Rate or URC
Hospital Miscellaneous	100%	Covered to the policy max per Policy Year Pre-admission testing to be included and done within 3 days of admission
Inpatient Surgery	100%	Of the Negotiated Rate or URC
In Hospital Doctor's Visits	100%	Limited to one visit per day
Outpatient Surgery	100%	Covered to Policy Max
Inpatient/ Outpatient Surgeon's Fee	100%	Covered to Policy Max
Anesthesia	100%	Covered to Policy Max
Assistant Surgeon / Nurse / Anesthetist (CRNA)	100%	Of the Negotiated Rate or URC
Doctor Office Visits	100%	Covered to Policy Max (\$0 Co-payment)
Laboratory, Diagnostic X-rays, Tests, Procedures and Injections	100%	Covered to Policy Max (\$0 Co-payment)
Chiropractic Care/ Physiotherapy	100%	\$1,000 combined Max per Policy Year
Speech Therapy	100%	Covered to Policy Max
Emergency Room Services	100%	Covered to Policy Max
Mental & Nervous	100%	Up to \$10,000 Max per Policy Year
Alcohol & Substance Abuse	100%	\$1,000 combined Inpatient/ Outpatient Max per Policy year
Maternity	100%	Covered to Policy max
Annual Pap Smear	100%	Covered One per Policy Year
Mammography Expense (One Per Policy Year)	100%	A baseline for women between ages 35- 40 every two years for woman 40 -50 and annually for women over 50
Newborn Hearing, Childhood Immunizations	100%	Covered to Policy Maximum from birth to thirty-six months
TSPOT and MMR	100%	One per policy Year (Student only) at Oxford Diagnostic Laboratories
DME (Durable Medical Equipment )	100%	Rental to purchase price
Ambulance Expense	100%	Covered to Policy Max per Policy Year
Accident Dental Injury (including Palliative Treatment)	100%	\$100 per tooth, max \$250 per Policy Year
Intercollegiate Sports	100%	\$10,000 max per occurrence per policy year
Home Country Coverage	100%	\$1,000 max up to 30 days per Policy Year
Prescription Drugs	100%	Required to use CVS Caremark Discount Card
Medical Evacuation and Repatriation	Deductible does not apply	\$100,000 max for each benefit per Policy Year

## WHEN COVERAGE BEGINS AND WHEN COVERAGE ENDS

**Effective Date** – The beginning date of the term for which premium has been paid.

The Effective Date for your eligible **spouse** or **dependents** enrolled with you is your Effective Date, provided the Company receives the required premium for the **spouse** or **dependent**. If a **spouse** or **dependent** becomes eligible after your Effective Date, you have 30 days from the date such **spouse** or **dependent** first becomes eligible to enroll them and pay the applicable premium.

**Automatic Coverage for Newly Acquired Dependents** - A newborn child will be automatically covered for the first 31 days after birth. An adopted child or child placed with you in anticipation of adoption will be automatically covered for 31 days from the date of placement. The automatic coverage of a newborn child or child placed for adoption will end on the 32<sup>nd</sup> day after birth or placement. Coverage for such a child will be the same as any other **dependent**, including medically diagnosed congenital defects, birth abnormalities, premature birth care and nursery care. You will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage you must, within the 31 days after the date of birth, adoption, or placement for adoption: a. Enroll such **dependent**; and b. Pay the required additional premium for the coverage. If you do not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child’s birth, adoption, or placement for adoption. If you need an enrollment form or have questions about your effective and termination dates please contact Trawick at 888-301-9289.

**Coverage Ends** - Your coverage ends on the earliest of the following: 1. The date you cease to be eligible for coverage; or 2. The end of your **term of coverage**. Your **spouse** or **dependent** coverage will end at the earliest of: 1. The end of the period for which the premium is paid for such **spouse** or **dependent** coverage; 2. The date a **spouse** or **dependent** is no longer eligible for coverage; or 3. The end of your **term of coverage**.

## ACCIDENTAL DEATH AND DISMEMBERMENT PRINCIPAL SUM

**Accidental Death Benefit** – the plan pays \$15,000 when your death occurs as a result of accidental **injury**. Loss of life must result within 90 days of the date of the accident causing such loss. Your coverage under the policy must be in force on the date of the accident and when loss of life occurs.

**Dismemberment Benefit** - If you sustain accidental **injury** that results in loss of a limb or sight the plan will pay the portion of the Principal Sum shown below. Loss must occur within 365 days of the accident causing such loss.

In the event of more than one loss only one sum, the largest, will be paid.

For injury resulting in the loss of:	<b>Indemnity</b>
Both hands or both feet or the sight of both eyes:	<b>\$15,000</b>
One hand and one foot, one hand or one foot and the sight of one eye:	<b>\$15,000</b>
One hand or one foot or the sight of one eye:	<b>\$7,500</b>

“Loss of hand or foot” means severance at or above the wrist or ankle joint.

“Loss of sight” must be entire and irrecoverable.

## **MEDICAL EXPENSE BENEFITS**

The plan will pay benefits for **covered expenses** incurred by you for loss due to **sickness** or **injury**, less any **deductible** and subject to subject to the **Schedule on page 2**: 1. The maximum benefit for all services as shown in the Schedule ; 2. The maximum amount for specific services as shown in the Schedule; and 3. Any **coinsurance** amount shown in the Schedule. **Covered expenses** are considered incurred when the covered service is rendered, provided there is a charge made for such service. The plan provides payment for services, procedures and supplies that are **medically necessary**. No benefits will be paid for expenses determined not to be **medically necessary**, including any or all days of **hospital stay**. The total payable for all **covered expenses** will not exceed the maximum benefit shown in the Schedule.

### **A. INPATIENT COVERED EXPENSES INCLUDE:**

#### **1. Hospital Services:**

**Room and Board Expense** - Daily semi-private room rate for a **hospital stay**; and General nursing care provided and charged for by the **hospital**.

#### **Intensive Care**

**Miscellaneous Expenses** - During a **hospital stay**; or As a precondition for a **hospital stay**. Benefits will be paid for 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. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

#### **Physiotherapy**

#### **2. Surgery Services:**

**Surgeon**

**Assistant Surgeon**

**Anesthetist**

**Nurses** -During a **hospital stay**; General nursing care provided by the **hospital** is not covered under this benefit.

**3. Doctor's Visits** - during a **hospital stay**. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

**4. Preadmission Testing** - limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the Hospital Miscellaneous Expenses benefit.

**5. Psychotherapy** - for the treatment of a mental or emotional disorder or of related bodily illness by psychological means where the psychotherapy is administered by a **doctor**.

**6. Alcohol and Substance Abuse**

**7. Mental and Nervous Disorders**

### **B. OUTPATIENT COVERED EXPENSES INCLUDE:**

#### **1. Surgery Services:**

**Surgeon**

**Assistant Surgeon**

**Anesthetist**

**Miscellaneous for Day Surgery** benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies.

**2. Miscellaneous Hospital and Doctor** - services payable as shown in the Schedule.

**3. Doctor's Visits**

**4. Physiotherapy**

5. **Medical Emergency** - as defined. Benefits will be paid as shown in the Schedule.
6. **Diagnostic X-ray Services** - as shown in the Schedule. Separate maximums apply to **positive** and **negative X-rays**. Diagnostic X-rays are only those procedures identified in (CPT) as codes 70000-79999 inclusive.
7. **Radiation Therapy**
8. **Laboratory Procedures** - are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
9. **Tests and Procedures** - a. Diagnostic services and medical procedures; b. Performed by a **doctor**; c. Excluding **Doctor's Visits**; Physiotherapy; X-rays; and Laboratory Procedures.
10. **Injections** - a. When administered in the **doctor's** office; and b. Charged on the **doctor's** statement.
11. **Prescription Drugs** - Must Use the Caremark Card
12. **Chemotherapy**
13. **Mammography**
14. **Well Child Visits, Newborn Sickle Cell Testing, Newborn Hearing, Childhood Immunizations** - newborn child from birth to thirty-six months of age. "Routine and necessary immunizations" means immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.
15. **Diabetic coverage** - includes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. As used herein, the terms "equipment" and "supplies" shall not be considered durable medical equipment. To qualify for coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.
16. **Pap Smear** - for annual testing performed by FDA-approved gynecologic cytology screening technologies.
17. **Speech Therapy**
18. **Maternity**
19. **Alcohol and Substance Abuse**
20. **Mental and Nervous Disorders**
21. **Durable Medical Equipment (DME)**
22. **T-Spot and MMR (Incoming Students only) when at Oxford Diagnostic Laboratories 877-59-TBLAB**

**C. OTHER SERVICES INCLUDE:**

1. **Ambulance Services**
2. **Braces and Appliances:** a. When prescribed by a **doctor**; and b. When a written prescription accompanies the claim when submitted. Braces and appliances include durable medical equipment which: Is primarily and customarily used to serve a medical purpose, Can withstand repeated use, and Is not generally useful to a person in the absence of **sickness** or **injury**. No benefits will be paid for rental charges in excess of purchase price.
3. **Consulting Physician** when requested and approved by the attending **doctor**. **Covered expenses** will be paid under this benefit or under the **Doctor's Visits** benefit, but not both on the same day.
4. **Dental Treatment** performed by a **doctor** and made necessary by **injury** or to relieve pain to **natural teeth**.

**D. ADDITIONAL COVERED SERVICES INCLUDE:**

1. **Repatriation** - The plan pays for repatriation up to \$100,000 while covered under the policy. This bene-

fit will be paid for preparing and transporting your remains to your Home Country.

2. **Emergency Medical Evacuation** – the plan pays up to \$100,000 for medical evacuation to your Home Country. while you are covered under the policy. This benefit will be paid: a. During a minimum **hospital stay**; and b. When recommended and approved by the attending **doctor**.

### DEFINITIONS

**Coinsurance** means the percentage amount of Covered Expenses, after the Deductible, which is Your responsibility to pay.

**Complications of pregnancy** means: a. Conditions whose diagnosis is distinct from but adversely affected or caused by pregnancy and which require a hospital stay (when pregnancy is not terminated). Such conditions include, but are not limited to, acute nephritis; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; and similar conditions of comparable severity; or b. Non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; and spontaneous termination of a pregnancy during a period of gestation when a viable birth is not possible. Complications of pregnancy do not include: False labor; Occasional spotting; Doctor-prescribed rest during pregnancy; Morning sickness; or Similar conditions associated with a difficult pregnancy that are not classified as a complication of pregnancy.

**Covered expenses** means charges: a. Not in excess of usual, reasonable and customary charge; 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.

**Covered person** means you and your eligible spouse and dependents covered under the policy. The proper premium payment must be made to be covered under the policy.

**Deductible** means the amount of Covered Expenses which is Your responsibility to pay before benefits under the Plan are payable.

**Dependent** means your unmarried child who: a. Has his principal residence with you; b. chiefly relies on you for support and maintenance; and c. Is under 26 years of age; The Company may, from time to time, require proof of the continuation of such condition and dependence. After that, required proof can be requested no more than once a year. “Child” can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

**Doctor** means a licensed practitioner of the healing arts acting within the scope of his license. Doctor does not include: a. You; b. Your spouse, dependent, parent, brother, or sister; or c. A person who ordinarily resides with you.

**Home Country** shall mean, the country where you have your fixed and permanent home establishment and to which you have the intention of returning.

**Hospital** means an institution: a. Operated pursuant to law; b. Primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; c. Under the supervision of a staff of doctors; d. Providing 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.); e. With medical, diagnostic and treatment facilities, and with major surgical facilities; 1) On its premises; or 2) Available on a prearranged basis; and f. Charging for its services. Hospital does not include a clinic or facility for: Convalescent, custodial, educational or nursing care; The aged, drug addicts or alcoholics; or Rehabilitation.

**Hospital stay** means a medically necessary overnight confinement in a hospital when room and board and general nursing care are provided and a per diem charge is made by the hospital.

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

**Intensive care** means: a. A specifically designated facility of the hospital that provides the highest level of medical care; and b. Restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. It must be: (i) Permanently equipped with special life-saving equipment for the care of the critically ill or injured; and (ii) Under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive care does not mean any of these step-down units: Progressive care; Sub-acute intensive care; Intermediate care units; Private monitored rooms; Observation units; or Other facilities not meeting the standards for intensive care.

**Medical emergency** means the occurrence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in: placing one's health (for a pregnant woman this includes the health of the newborn) in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any body organ or part. Expenses incurred for medical emergency will be paid only for an illness or injury fulfilling the above conditions. These expenses will not be paid for minor illness or minor injuries.

**Medically necessary** means those services or supplies provided or prescribed by a hospital or doctor: a. Essential for the symptoms and diagnosis or treatment of the illness or injury; b. Provided for the diagnosis, or the direct care and treatment of the illness or injury; c. In accordance with the standards of good medical practice; d. Not primarily for your convenience or that of your doctor; and e. That are the most appropriate supply or level of service that can safely be provided.

**Natural teeth** means natural teeth or teeth where the major portion of the individual tooth is present, regardless of fillings or caps, and is not carious, abscessed, or defective.

**Negative X-ray** means an X-ray that shows the absence of a fracture, pathology, or disease.

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

**Participating institution** means the college or university you attend during your period of coverage.

**Physiotherapy** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a doctor.

**Positive X-Ray** means an X-ray that shows the presence of a fracture, pathology, or disease.

**Prescription** means any authorization, including authorized refills, issued by a doctor for dispensing medication for the purpose and in the amount specified.

**Prescription drug** means: a. A legend drug; b. A compound medication when at least one ingredient is a prescription legend drug; c. Any other drug which under applicable state law may only be dispensed by prescription, including injectable insulin; or d. Drugs and medications dispensed by a licensed pharmacist that are not specifically excluded by other provisions applicable to this coverage.

**Primary insured** means you.

**Sickness** means illness or disease diagnosed during the Period of coverage under the Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of sickness will be considered one sickness.

**Spouse** means your lawful spouse.

**Usual, reasonable and customary (URC)** means: 1. Charges and fees for medical services or supplies that are the lesser of: a) The usual charge by the provider for the service or supply given; or b) The average

charged for the service or supply in the area where service or supply is received; and 2. Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

### CONFORMITY OF LAW

Any provision of this policy which, on its Effective Date, is in conflict with the laws of the state in which the policy is delivered or issued for delivery, is considered amended to conform to the applicable requirements of such state.

### EXCLUSIONS AND LIMITATIONS

#### PRE-EXISTING CONDITIONS

**“Pre-existing Condition”** means – an illness, disease or other condition, that in the 12 month period before your coverage became effective under the Policy: 1. first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or 2. required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3. was treated by a Doctor or treatment had been recommended by a Doctor.

**The “Pre-existing Condition Waiting Period”** is 12 months. If you receive treatment or service for a Pre-Existing Condition: a) No benefits will be paid for such condition until the day after a 12 **consecutive** month period has passed from your effective date; and b) The plan will pay only for Covered Expenses incurred after such 12 consecutive month period.

The **Pre-existing Condition Waiting Period** will be reduced by the aggregate period of credible coverage if the Credible Coverage was continuous to a date not more than 63 days before the Effective Date of coverage. Payment will be in accord with the provisions of this plan. If you have a lapse in coverage for more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

#### EXCLUSIONS

No benefits will be paid for loss or expense caused by or resulting from:

1. **Injury** of the **primary insured** covered under any student accident insurance policy underwritten by us.
2. Any **Pre-existing Condition**, unless the waiting period or continuous coverage are applied.
3. Services and supplies furnished normally without charge by the **participating institution’s** infirmary, its employees, or **doctors** who work for the **participating institution**.
4. Services covered or provided by the student health fee.
5. Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of injury except those as provided.
6. Preventive medicines, serums, vaccines except as provided.
7. Eye examinations, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a **covered expense** associated with a **sickness** or **injury** covered by the policy.
8. Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a **covered expense** associated with an **injury** covered by the policy.
9. Dental treatment, unless payable under *Accident Dental Injury* .
10. War or any act of war, declared or undeclared, or while in the armed forces of any country.



11. Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense.
12. Intentionally self-inflicted **Injury**, suicide or any attempt thereat.
13. **Injury** sustained while: a. Participating in any school, professional or organized sports contest or competition; b. Traveling to or from such sport, contest or competition as a participant; or c. During participation in any practice or conditioning program for such sport, contest or competition; **except specifically provided for in the schedule under Intercollegiate Sports Benefit.**
14. Skydiving; parachuting or bungi-cord jumping, hang gliding, glider flying, parasailing, sail planing, or flight in any kind of aircraft, except while riding as passenger on a regularly scheduled flight of a commercial airline.
15. Treatment in a military or Veterans Hospital or a **hospital** contracted for or operated by a national government or its agency unless: a. The services are rendered on an **medical emergency** basis; and b. A legal liability exists for the charges made on your behalf for the services given in the absence of insurance.
16. **Injury** caused by, or resulting from, the use of alcohol, controlled substance, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the person's **doctor**.
17. Psychotherapy, except as specifically provided for in the Schedule.
18. Elective surgery and elective treatment, except as required to correct an **injury** for which benefits are otherwise payable under the policy.
19. Any loss covered by state or federal worker's compensation law, employers liability law, occupational disease law, or similar laws or act.
20. Replacement braces and appliances.
21. Expense incurred within your **home country** or country of regular domicile which exceed \$1,000 or 30 days.
22. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column which exceed the maximum in the Schedule.
23. That part of medical expense payable by any automobile insurance policy without regard to fault.
24. Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and: (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and (ii) You are within a 25-mile radius of the site of the release either: At the time of the release; or Within 24 hours of the start of the release.
25. Travel in or upon: a. A snowmobile; b. Any two-or three-wheeled motor vehicle; or c. Any off-road motorized vehicle not requiring licensing as a motor vehicle.
26. Any accident where you are the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license, except while in a Driver's Education Program.
27. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan.
28. Blood or blood plasma, except for charges by a **hospital** for the processing or administration of blood.
29. Rest cures or custodial care.
30. Personal services such as television and telephone or transportation.
31. A hernia of any kind.
32. Treatment for acne.

## TIME LIMITS FOR COVERED LOSS

Covered expenses will be paid as shown in the Schedule on Page 2: 1. Due to **injury** when: a. The accident causing the injury occurs before the end of your term of coverage; b. Treatment by a doctor begins within 30 days after the date of the accident causing **injury**; c. Treatment and services received are included under the definition of **covered expenses**; and d. All treatment is received within 52 weeks of the beginning of care. 2. Due to your sickness provided: a. Treatment by a doctor begins during your term of coverage; b. Treatment and services received are included under the definition of covered expenses; and c. All treatment is received within 52 weeks of the beginning of care.

**Extension of Benefits** - If you are under the care and treatment of a **doctor**, benefits will continue to be paid for that condition for a period of up to 3 months following the end of the term of coverage, or until the maximum benefit has been paid, whichever occurs first.

**Continuous Coverage** - If you are continuously covered under the policy offered through your **participating institution** you will be covered for any **sickness** diagnosed or **injury** sustained while so covered. If you are enrolled for coverage offered through your **participating institution** within 63 days of the end of any preceding company's policy, you will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 63 days occurs.

## GENERAL PROVISIONS

**Subrogation** - When benefits are paid to or for you under the terms of the policy, the Company shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such person against any person who might acknowledge liability or found legally liable by a Court of competent jurisdiction for the **sickness** or **injury** that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by the Company of the benefits they have paid for such hospitalization and treatment and shall pay fees and costs associated with such recovery. The person agrees to sign papers and do whatever else is necessary to transfer his rights to the Company. They will exercise such rights on your behalf. You further agree to furnish us with all relevant information and documents.

**Coordination of Benefits** - If you are eligible for benefits under this policy and any other plan, the Company will pay benefits as explained in this provision. To determine how this provision should apply, the Company may, without further consent or notice, release to or obtain any necessary information from other insurance companies or organizations. Any person claiming benefits under the Policy shall give the Company the information needed to implement this provision. You will receive notice of this exchange of claim and benefit information when the claim is filed. Whenever payments are made by another Plan of Health Coverage that should have been paid under the Policy, the Company shall pay any amount required to satisfy their share of the benefits paid. Any amounts paid in this way will be considered benefits paid under the Policy. Any payment made in good faith will end our liability to the extent of the payment. If the Company pays benefits for Covered Expenses that exceed our obligation under this provision, they may recover the excess payment from any person, for whom benefits were paid; any person

or organization to which benefits were paid; or from any other insurer, service plan or other organization.

**Right of Recovery** - Payments made by the Company which exceed the **Covered expenses** (after allowance for **deductible** and any **coinsurance** clauses) payable hereunder shall be recoverable by us from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered **injury** as their liability may appear.

## PRE-AUTHORIZATION

**USA/Canada Toll Free: 1-877-916-7920**  
**Upon completion Fax Authorization Form To: 1-905-669-2524**

Pre-authorizations are subject to certification by the Plan Administrator. Pre-certification may be done by you, your **doctor**, a hospital administrator, or one of your relatives. Certain medical procedures or treatments will require a request form to be received by the Company or the Company's authorized representative. This must be received a minimum of **5** business days prior to the scheduled procedure date if the procedure is elective, or within **48 hours** after the initial admission if the admission is due to an emergency. **Approval** from the Company must be given prior to the commencement of the proposed medical treatment. If certification is received, covered charges will be paid as shown in the Schedule of Benefits. ***Failure to comply with prior authorization procedures will result in a 20% reduced benefit penalty, provided that the care is determined to be a procedure that would have been approved by the Plan Administrator.*** If upon review of medical records, it is determined to be a medical procedure which would not have been approved, the entire claim and all related charges will be denied. Pre-authorization is based on information provided to the Company at the time of request, and does not guarantee payment of benefits nor verify eligibility. Payment for services is subject to all terms, conditions, limitations and exclusions related to the member's eligibility and subsequent medical review. Regardless of pre-authorization status, medical decisions concerning a course of treatment are solely between the **doctor** and you.

### **Services requiring prior authorization are:**

1. All Inpatient admissions and/or treatments, including but not limited to Admissions to an Inpatient Facility or Partial Hospitalization Unit; Emergencies must be post-certified **within 48 hours** of discharge or as soon as reasonably possible.
2. Any surgeries requiring general anesthesia (Outpatient or Inpatient);
3. Accidental Dental treatment (for emergency dental repair of **natural sound teeth** damaged in an Accident);
4. Purchase or rental of Durable Medical Equipment;
5. RSV Immunization and other medications priced in excess of \$1,000 per refill;
6. All cancer treatments/therapies;
7. Hemodialysis and Peritoneal Dialysis for renal failure;
8. Substance Abuse treatments/therapies.

## PRESCRIPTIONS

CareMark—Customer Service 866-259-0798  
Provide Member ID from your ID card

## CLAIMS STATUS, ELIGIBILITY VERIFICATION & COVERAGE QUESTIONS

GBG Administrative Services  
26741 Portola Pkwy Ste. 1E #527  
Foothill Ranch, CA 92610  
Toll Free: 877-916-7920 Fax 949- 919-7943



Submit claims online or check status at <http://www.studentinsure.com/memberservices.asp?schoolid=89>

Use the MEMBER SERVICES tab to find the claim login

- Finding a provider who accepts this insurance at <http://gbg.canmednet.com/wps/> and type in your zip code to locate a provider in your area.
- Provide the hospital or doctor with a copy of your ID card so they can bill us for the services provided to you. This shows your member ID and is how to find you in our system to verify benefits. Failure to give the correct information to the provider could result in bills getting sent to you, instead of the insurance company.
- All claims, regardless of submission date, **must be received in our office within 90 days of treatment or they will be denied.** Initial treatment must occur within 90 days of the Accident or Sickness.
- Once a claim has been reviewed, additional documentation may be required for processing. This request will be made in writing to the address on file. Please make sure your address is current in our database.
- To update or check the address log on to our website [www.studentinsure.com/asu](http://www.studentinsure.com/asu)
- Click "Update Member Info"- located at the top of the webpage
- Your Insurance ID is the number beginning with **999...**
- Your default password is your last name. You can change your password at any time.
- Make sure your name and birth date are correct then update your **current** address, email address, change your password if necessary, select the HTML option for email and click **SAVE**.
- After a claim has been processed you and the provider will receive an explanation of benefits (EOB). This explanation has a claim number, date of service, paid date, amount paid, amount applied to your deductible and an explanation as to why/how the claim was processed. The EOB will also state if you owe the provider anything for the service. If there is a reimbursement to you, a check will be attached. **If you get a bill from a provider and do not get an EOB from us within 60 days please contact us at the number above for claim status.**
- If a claim is denied you will receive a written explanation on the EOB. If you feel the decision is wrong, you have the right to appeal the decision which must be done in writing within 6 months of receiving the EOB. You can get an appeal form by calling the claim office at **877-916-7920**.

This is a brief description of coverage provided under group policy number **US100833**, form number IN/OUT-04 , and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy and certificate for details. Coverage may vary or may not be available in all states.



Visit our website at [www.studentinsure.com/asu](http://www.studentinsure.com/asu) where you can print a temporary ID card, download or print a brochure, change your address, search for forms, and file or check the status of a claim. If you have questions about your enrollment or if you can't login to the website please contact your student advisor or Trawick International Enrollment Department at **Toll Free: 1-888-301-9289**