UNITED WORK & TRAVEL
A division of American Pool Enterprises, Inc.

PHCS

Policy # SRPO-51052-1286

Valid only for the dates of your approved program.
To verify eligibility, call Member Services:
800-427-9308
For a claim form, to reprint this card or to get more info, go to: **www.amastudentplans.com/uwt**

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE.

Underwritten by: AXIS Insurance Company

PHYSICIAN VISIT
$150 Deductible
EMERGENCY ROOM
PER INJURY IF NOT ADMITTED $100 Deductible to a medical expense of $1,000 maximum
PER INJURY OR SICKNESS IF ADMITTED $250 Deductible
PER EMERGENCY SICKNESS IF NOT ADMITTED $250 Deductible to a medical expense of $1,000 maximum

Dear United Work and Travel Program Participant:

Welcome to the J-1 Summer Work/Travel cultural exchange program! This letter is to inform you about your program **Accident and Injury Medical Insurance**. Please take extra care in reading all of your insurance information and if something is not clear, please contact us for clarification prior to visiting a medical facility.

Policy Coverage Information:

Insurance Company:	Axis Insurance Company
Policyholder	United Work and Travel, A division of American Pool Enterprises, Inc.
Provider search	www.multiplan.com 1-800-922-4362
Claim Administrator:	**MCA Administrators, Inc.; PO Box 6540, Harrisburg, Pa 17112** **1-800-427-9308**
Coverage Website:	www.amastudent plans.com/uwt

Your Insurance Company is **Axis Insurance Company**. The maximum payable benefit under the policy is $100,000. There is a $150 deductible per accident or illness for a physician's visit. Your insurance policy does not cover: pre-existing conditions, pregnancy, sexually transmitted disease, self inflicted injury (while sane or insane), accident or injury related to substance use or abuse. Please refer to the **description of benefits for full coverage information.**

Most Urgent Care Facilities are now covered under your insurance plan. You will need to pay your deductible per visit, and the insurance company will review payment for the remainder of the medical expenses provided it is a covered expense and within Usual and Customary.

For every medical visit you will be required to fill in and complete a student insurance claim form. The hospital or Doctor form will not be enough. Axis Insurance Company will not make ANY payments on your behalf if you do not complete this form. The first page of the student claim form must be completed and sent into the claim administrator EVERY time you visit the doctor, emergency room, clinic or hospital, regardless of the outcome of your visit.

United Work and Travel, a division of American Pool Enterprises, Inc. is NOT your insurance company. We are the group policyholder with which your accident and injury insurance is held. Therefore, all completed claim forms should be sent to the Claim Administrator's address above to be processed. As your Sponsor, United Work and Travel has no jurisdiction over the claims process or outcome.

If you have any additional questions about your program insurance, please email our team at students@unitedworkandtravel.com.

HOW TO USE YOUR PROGRAM INSURANCE...

United Work and Travel
A division of American Pool Enterprises, Inc
Policy # ARPO-51052-1286
Underwritten by: Axis Insurance Company

To Find a Provider:

Logon to website **www.multiplan.com** (PHCS is a division of Multiplan)
On right hand side of the screen check network PHCS
(Go)
Choose Provider type (hospital and facilities or Physicians)
Use **Primary Care** for physicians
Use **Specialists** for specific type doctor (heart, surgeon,etc.)
Use**Facility** for **Urgent Care Clinics**
Enter miles and zip code.
Type of Facility
Outpatient Care
Urgent Care or Outpatient Clinic (continue)
A Listing will Appear

To Call for an Appointment with a Network Provider

You need to tell the Provider that your group is part of the PHCS/Multiplan network. **Do not tell them that you are United Work and Travel.(They will not know who you are)**

If you have difficulty making an appointment:
contact Provider Services at 1-800-922-4362; or the Plan Administrator at 1-888-533-7654.

During Scheduled Appointment:

You must have your ID card with you and money to pay for your deductible. All instructions for the **claim department address and verifying eligibility are on the back portion of your card.**

After your Appointment:

Go to website**www.amastudentplans.com/uwt**and download a claim form. Complete the claim form including all details requested and send to the Claim Administrator at the address on your ID card. (**MCA Administrators, Inc; PO Box 6540; Harrisburg, Pa 17112)**

Needed to Pay a Claim:

Itemized bills from the Provider & Completed and signed Claim form

How to file a Medical Claim

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

Attached is a claim form for your accident policy.
Please forward claims and questions to the following address:

MCA Administrators, Inc
P O Box 6540
Harrisburg, Pa 17112
1-800-427-9308
Student-insurance@mcoa.com

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

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

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

The Parent/Guardian or Adult Claimant should:

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

Step 2: **Submit itemized medical bills for payment consideration to our office. If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs).**

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will not be paid pending receipt of the missing information.
- The acceptance of a claim form by an Insurance company is not an admission of coverage
- Providers may wish to bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for Physician Charges).
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO

MCA Administrators, Inc
P O Box 6540
Harrisburg, PA 17112

Phone: 1-800-427-9308
Student-insurance@mcoa.com

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity or Sport:

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

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

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

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

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

Describe How Accident Occurred – Provide All Possible Details

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

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

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

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐YES ☐NO

If Yes, name of insurance company::_____ Policy #:_____

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

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

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

☐YES ☐NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

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

SIGNATURE _____ DATE _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***AXIS Insurance Company*** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***AXIS Insurance Company*** to the extent of any amount collectible.
I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

Important Notice

- ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ***For residents of Maine, Tennessee, Virginia and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

This is a Description of Coverage for

United Work and Travel, Inc.

a Division of American Pool Enterprises, Inc.

Underwritten By: AXIS Insurance Company (herein referred to as "the Company')

Eligibility: You will be covered under this plan if you are an active- Non-US participant of the policyholder participating in the Work & Travel programs conducted by United Work and Travel, Inc.

Period of Coverage: Coverage will begin: a) for Accidental Death & Dismemberment Benefits, the time of departure from the Insured Person's point of last domicile or temporary residence in their Home Country directly to the point of embarkation on the scheduled program of United Work and Travel, Inc; and b) for all other benefits, the time of the insured's departure from their Home Country. Coverage will end: a) for Accidental Death & Dismemberment Benefits, the time of return to the Insured Person's domicile or temporary residence in their Home Country directly from the point of disembarkation from the scheduled program of United Work and Travel, Inc. for benefits and b) for all other benefits, the time of arrival in the Insured Person's Home Country. This insurance only covers the participant while he/she is participating in an intern program at the direction and expense of United Work and Travel, Inc.

Definitions: Sickness: means an Illness, disease or condition of the Insured Person that causes a loss for which an Insured Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness.
Covered Injury: means Accidental bodily injury: (1) which is sustained by an Insured Person as direct result of an unintended, unanticipated Covered Accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force; (2) which results directly and independently from all other causes from a Covered Accident; and (3) which occurs while such person is participating in a Covered Activity. The Covered injury must be caused through Accidental means. All injuries sustained by an Insured Person in any one Covered Accident, including related conditions and recurrent symptoms of these injuries, are considered a single injury. **Home Country:** means a country from which the Insured Person holds a passport or where the Insured Person has primary residency. If the Insured Person holds passports from more than one Country, His Home Country will be the country that He has declared to Us in writing as His Home County. **Medically Necessary:** means medical services that: (1) are essential for diagnosis, treatment or care of the Covered Injury for which it is prescribed or performed: (2) meets generally accepted standards or medical practice; and (3) are ordered by a Physician and performed under His care, supervision or order. **Usual and Customary Charge (s):** (1) is made for a Covered Medical Service; (2) does not exceed the usual level of charges for similar treatment, services or supplies in the locality where the expense is incurred (for a Hospital room and board charge, other than for Medically Necessary stay in an intensive care unit or a cardiac care unit, does not exceed the Hospital's most common charge for semi-private room and board); and (3) does not include charges that would not have been made if no insurance existed.

Medical Expense Benefits: If a covered Injury or Sickness occurs during the Period of Coverage and the Insured Person requires medical or surgical treatment, The Company will pay:

Medical Expense	In Network	Out of Network
$1 - $2,500	Paid at 100% of negotiated fee	Paid at 90% of Usual & Reasonable
$2,500 - $10,000	Paid at 80% of negotiated fee	Paid at 70% of Usual & Reasonable
$10,000 - $100,000	Paid at 100% of negotiated fee	Paid at 90% of Usual &

Reasonable In no event will: (1) the Company's liability exceeds $100,000 for each covered Injury or Sickness; and (2) Covered Expenses exceed the usual and customary expenses for the geographical area where the services are rendered, as determined by the Company.

Deductible: (The dollar amount for which you are responsible and after which policy benefits will be paid)

$150.00 per accident or sickness per Doctor visit.

Emergency Room

$ 100.00 deductible to maximum of $1,000 – Injury only - Outpatient

$ 250.00 deductible per emergency sickness to maximum of $1,000 – Outpatient

$ 250.00 deductible per accident or sickness if admitted

Emergency Sickness: means an Illness or disease diagnosed by a Physician which: (1) causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the Insured Person's health or place His life in jeopardy; and (2) first manifests itself suddenly and unexpectedly while the Insured Person is covered under this Policy and is participating in a Covered Activity.

To be considered a Covered Expense under this plan, it must: a) have been incurred as the result of and within 52 weeks of a covered Sickness or Injury outside of the Home Country during the Period of Coverage; b) not be excluded by provisions of this Plan; and c) be specifically included in the following list of expenses:

1. Expenses made by a hospital for room and board, including registered nursing services and any other medically necessary hospital services, but not including personal services of a non-medical nature. However, allowable expenses may not exceed the hospital's average charge for semiprivate room and board accommodation.
2. Expenses made for diagnosis, treatment and surgery by a doctor.
3. Expenses made for the cost and administration of anesthetics.
4. Expenses for x-ray services, laboratory tests and services
5. Expenses for durable medical equipment (includes rehabilitative braces and appliances, both inpatient and outpatient).
6. Expenses for Physiotherapy, if recommended by a Doctor for the treatment of a specific disablement administered by a licensed physiotherapist, subject to a maximum benefit 20 days per policy year, inpatient only.
7. Expenses for dental expenses resulting from an injury to sound, natural teeth, up to; $1,000 maximum benefit per occurrence; Alleviation of Pain; Maximum Benefit $500 per occurrence.
8. Outpatient surgery & related ancillary expenses – maximum of $1500
9. Outpatient prescription drug expense - 100% inpatient and 100% outpatient subject to a $25 deductible per prescription.
10. Pregnancy (and related medical complications) - $0

Emergency Medical Evacuation Benefit

We will pay Emergency Medical Evacuation Benefits as shown in the Schedule of Benefits for expenses incurred for the medical evacuation of a Insured Person. Benefits are payable if the Insured Person:

1. is traveling outside of his or her Home Country;
2. suffers an Injury or Sickness during the course of the Trip; and
3. requires Emergency Medical Evacuation.

Benefits will not be payable unless:

1. the Physician ordering the Emergency Medical Evacuation certifies the severity of the Insured Person's covered Injury or Sickness warrants an Emergency Medical Evacuation;
2. all transportation arrangements for the Emergency Evacuation must be by the most direct and economical Conveyance and route possible;
3. the charges incurred are Usual & Customary and are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and do not include charges that would not have been made if there were no insurance.

Medical Evacuation and Repatriation are services provided by Generali Global Assistance and are not insured benefits. Generali Global Assistance can make arrangement for these services whenever Insured Persons and Covered family members travel at least 100 miles away from home.

Medical Evacuation and / or Medical Repatriation when the Insured Person's Covered Injury or Emergency Sickness warrant emergency evacuation (depending on the cause of the medical condition requiring evacuation or repatriation), this policy may pay for the cost of the evacuation or repatriation when the Medical Evacuation Benefit applies.

An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation.

Repatriation of Remains when the insured person suffers loss of life due to a Covered Injury or Emergency Sickness. This policy may pay for the cost of the repatriation of remains if the Repatriation Benefit applies.

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance.

Repatriation of Remains Benefit
We will pay Repatriation Benefits as shown in the Schedule of Benefits for preparation and return of a Covered Person's body to his or her Home Country id he or she dies due to an Injury or Sickness. Covered Expenses include:

1. expenses for embalming or cremation;
2. the least costly coffin or receptacle adequate for transporting the remains;
3. transporting the remains by the most direct and least costly conveyance and route possible.

*If the expenses associated with the Travel Assistance Services or any advanced payment are not covered under the insurance policy, the policyholder or the covered person shall be responsible for payment. We reserve the right to recover any amounts paid outside the terms of the policy from any third party who would otherwise by responsible for payment in the absence of the policy benefits

Benefits will not be payable unless We authorize in writing or by an authorized electronic or telephonic means all expenses in advance.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
If Injury to the Insured Person results, within the Time Period for Loss from date of Accident shown in the Schedule of Benefits, in any one of the losses shown below, We will pay the Benefit Amount shown below for that loss. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Accident. The Principal sum is $15,000

Covered Loss Benefit Amount:

Life	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Two or more Members	100% of the Principal Sum
One Member	50% of the Principal Sum
Hemiplegia	75% of the Principal Sum
Paraplegia	75% of the Principal Sum
Uniplegia	25% of the Principal Sum
Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Four Fingers of the Same Hand	25% of the Principal Sum

"Quadriplegia" means total Paralysis of both upper and lower limbs. "Hemaplegia" means total Paralysis of the upper and lower limbs on one side of the body. "uniplegia" means total Paralysis of one lower limb or one upper limb. "Paraplegia" means total Paralysis of both lower limbs or both upper limbs. "Paralysis" means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing. "Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent Loss of Sight of one eye. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means. "loss of a Thumb and Index Finger of the Same Hand" or "Loss of Four Fingers of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the finger and the hand). "Severance" means the complete separation and dismemberment of the part from the body.

Excess Benefits: All benefits, except Accidental Death and Dismemberment, shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.

Exclusions:
In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted Injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by the Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non-directly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribe dosage;
9. injuries compensable under Workers' Compensation law or any similar law;
10. bungee-cord jumping, parachuting, skydiving, parasailing, or hang-gliding;
11. operating any type of vehicle or Conveyance while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;

12. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
13. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
14. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
15. a cardiovascular, event or stroke resulting, directly and independently of all other causes, from exertion, as verified by a Physician, while the Insured Person participates in a Covered Activity;
16. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of Covered Injury; or
17. benefits will not be paid for services or treatment rendered by any person who is:
    (a) employed or retained by the Policyholder;
    (b) living in the Insured Person's household;
    (c) an Immediate Family Member of either the Insured Person or the Insured Person's Spouse; or
    (d) the Insured Person

Out of Country Medical Benefits are not payable for, and Usual and Customary Charges for Covered Medical Services do not include, any expense for or resulting from:

1. sickness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
2. Injury sustained while participating in professional athletics;
3. routine physical and care of any kind;
4. routine dental care and treatment;
5. cosmetic or plastic surgery, except as the result of a Covered Injury;
6. routine nursery or routine child care;
7. any mental or nervous disorder or rest cures;
8. eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eyeglasses, contact lenses, and/or hearing aids;
9. services, supplies, or treatment including any period of Hospital Confinement which is not recommended, approved; and certified as Medically Necessary and reasonable by a Physician, or expenses which are non-medical in nature;
10. in connection with alcoholism and drug addiction, or use of any drug or narcotic agent;
11. motorcycle driving, scuba diving, skiing, mountain climbing, skydiving, professional or amateur racing, bungee jumping, and piloting any aircraft;
12. expenses incurred during holiday travel, or travel for the purposes of seeking medical care or treatment, or for any other travel that is not in the course of the Policyholder business (unless Personal Deviation ae specifically covered);
13. charges for Covered Medical Expenses for which the Insured Person would not be responsible for in the absence of this Rider;
14. Injury or Sickness for which benefits are payable under any Worker's Compensation or occupational disease law or act, or similar legislation whether Unites Stated federal or foreign law.

Claims Administrators: MCA Administrators, Inc.; PO Box 6540; Harrisburg, PA 17112 Toll Free 1-800-427-9308 Fax 717-652-8328.
A CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM.
Preferred Provider Organization: PHCS – 800.922.4362 http://www.multiplan.com

Emergency Assistance: 800 961-2755 or 240 330-1495 (collect). Email: ops@us.generaliglobalassistance.com Generali Global Assistance offers MORE than travel insurance. Sure, we protect and provide compensation for trip cancellation, trip delay, personal article loss, accident, injury, illness and more. We also pride ourselves in being the "leader in Worldwide Assistance." This ensures that every traveler is personally cared for as if they were a member of our family. We are dedicated and it shows in our attention to each and every detail. Doing business with us is simple and easy.

We are so committed to assistance that we put our name on it. As the leader in global assistance, **Generali Global Assistance** provides each policy holder with:

- personal assistance with luggage tracking, lost passport/documents, prescription replacement, medical coordination, concierge services and more
- 24/7/365 accessibility with assistance in the customer's own language
- Office in over 100 countries
- Direct Access to over 60 Regional Assistance Centers strategically located around the globe.
- A worldwide network of 400,000 providers
- Travel and emergency assistance services to over 7 million individual travelers each year

Program Arranged By: AXIS Insurance Company Policy number: SRPO-51052-1286 Effective: 12/01/2017 Terminates: 11/30/2020
Claim forms and instruction are available from the website: www.amastudentplans.com

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 SRPO-51052-1286. The policy is subject to the laws of the state in which it was issued (Delaware). Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.