2018-2019

Student Injury & Sickness Insurance Plan

Policy #: EXL-SA10006-18
www.MyUSFInsurance.com

University of St. Francis (the "Policyholder")

2018 - 2019 Student Injury & Sickness Insurance Plan (the "Plan")

Policy #: EXL-SA10006-18 (the "Policy")

Underwritten by:

Administered by:

Insurance Underwritten By: Sirius America Insurance Company, with its principal place of business in New York, New York (the "Company")

Please keep this brochure as a general summary of the insurance. This brochure is a brief description of the coverage available under the Policy. The Policy contains full details of the coverage. If the contents of this brochure conflict with the Policy, please remember that the Policy governs.

PLAN ELIGIBILITY

Student Eligibility

All traditional students who are registered for 12 or more credit hours are eligible for the plan.

Students are automatically enrolled in the Plan; *however*, students may waive enrollment in the Plan by providing proof of comparable coverage under another health insurance plan. To waive enrollment in the Plan, a student must provide proof of comparable coverage prior to the waiver deadline of September 30, 2018.

PLAN COSTS

The annual cost for coverage is $1,844 (including administrative fees) per student. Plan costs (premium and administrative fees) are charged as part of the students' tuition.

POLICY EFFECTIVE & TERMINATION DATES

The Policy is effective at 12:01 a.m. on August 1, 2018. Thereafter, coverage for the insurance is effective 24 hours a day. Coverage will terminate at 12:01 a.m. on the last date of the insurance; the last date of the insurance is the earliest of the three following dates: (1) the date on which the Policy terminates; *or* (2) the premium due date on which the required premium has not been paid; *or* (3) the date on which the Covered Person ceases to meet the eligibility requirements of the Plan.

DESCRIPTION OF COVERAGE

If a Covered Person incurs expenses while insured under the Policy due to an Injury or Sickness, the Plan will pay the Allowable Charges for Medically Necessary Covered Medical Expenses listed in the Medical Expense Benefit section. All Covered Medical Expenses incurred as a result of the same or related cause, including any complications, will be considered as resulting from one Injury or Sickness. Benefits are subject to the Deductible Amount, Co-payments and Coinsurance Percentages, specified benefits set forth under Covered Medical Expenses, the limitations appearing under Limitations on Covered Medical Expenses, the General Policy Exclusions, and to all other limitations and provisions of the Policy. All medical benefits are subject to coordination of benefits (COB).

The expenses must be incurred after the effective date of the Covered Person's insurance while coverage remains continuously in force under the policy.

DESCRIPTION OF BENEFITS

In-network

The Covered Person must pay the $100 per person annual Deductible[1] before benefits are paid. After the Deductible[1] and Co-payments[2] have been satisfied, the Plan pays a percentage of benefits equal to 80% (after payment of 20% Coinsurance[3]) of covered expenses until the Covered Person reaches the per-person Out-of-Pocket[4] Maximum of $6,600. Once the Covered Person has satisfied their out-of-pocket maximum, it will be 100%. The plan will pay 100% of covered expenses for mandated preventive services as described in the Medical Expenses Benefits section. Services rendered at the Student Health Center (SHC) and prescriptions filled at the SHC dispensary are paid at 100% and are not subject to deductibles and/or co-pays unless otherwise specified.

In addition, there is a $75 per person Co-Payment[2] for urgent care facility visits and a $250 per person Co-Payment[2] for emergency room visits.

Out-of-network

The Covered Person must pay the $100 per person annual Deductible[1] before benefits are paid. After the Deductible[1] and Co-payment[2] have been satisfied, the benefit percentage the plan pays is 60% (Coinsurance[3] is 40%) of covered expenses until the Covered Person reaches the Out-of-Pocket[4] Maximum of $14,300. Once the Covered Person has satisfied their out-of-pocket maximum, it will be 100%.

In addition, there is a $75 per person Co-Payment[2] for urgent care facility visits and a $250 per person Co-Payment[2] for emergency room visits.

Outpatient Prescription Drugs[5]

The Covered Person is responsible for the applicable Co-payments[2], and the Plan pays 100% of the benefits after the applicable Co-payment has been paid. The Co-payments for Covered Persons are as follows:

Generic Drugs..$25 per prescription
Brand Name Prescriptions ....$50 per prescription
Specialty Brand Name Prescriptions ....$50 per prescription

[1] The deductible is the amount of Covered Expenses the Covered Person owes before the plan will pay for Covered Expenses.

[2] Co-payment is defined in the Definitions section of this brochure.

[3] Coinsurance means the portion of Covered Expenses that the Covered Person must pay.

[4] The Out-of-Pocket expenses are the Deductible, Co-payments and Coinsurance amounts that the Covered Person is responsible to pay. (Limitations and Exclusions are NOT included in calculating Out-of-Pocket.)

[5] Prescription Drug Co-payments apply to 30-day supplies.

MEDICAL EXPENSES BENEFITS

- Hospital room and board expense.
- Hospital miscellaneous expenses (operating room, lab tests, X-ray examinations, anesthesia, drugs, therapeutic services and supplies).
- Inpatient physiotherapy/occupational therapy.
- Inpatient and outpatient surgery.
- Inpatient and outpatient anesthetist services.
- Inpatient registered nurse's services and inpatient and outpatient physician's visits.
- Pre-admission testing.
- Inpatient and outpatient psychotherapy.
- Inpatient and outpatient consultant physician fees.
- Skilled Nursing Facility 120 days per admission).
- Outpatient surgery miscellaneous expenses (for example, operating room, anesthesia, drugs, therapeutic services and supplies).
- Outpatient physiotherapy/occupational therapy.
- Outpatient medical emergency expenses.
- Outpatient diagnostic x-ray services and laboratory procedures.
- Outpatient radiation therapy.
- Outpatient physician tests and procedures.
- Outpatient injections and chemotherapy.
- Outpatient prescription drugs.
- Ambulance services.
- Outpatient braces, appliances and durable medical equipment.
- Dental treatment, subject to limitations discussed in the section of this brochure entitled, "Benefit Limitations: Medical Expenses."
- Infusion Therapy.
- Dialysis Treatment.

- Transplant Surgery (When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of the plan).
- Rehabilitative and Habilitative services.
- Reconstructive breast surgery.
- Outpatient Speech Therapy.
- Outpatient Cardiac Rehabilitation (limited to 3 sessions per week and 3 months of treatment per policy year).
- Chiropractic Care (limited to 30 visits per policy year).
- Maternity, Prenatal and Newborn Care.
- Hospice Care.
- Sterilization including female tubal ligation and male vasectomy.
- Sexual Dysfunction Services.
- Pulmonary and respiratory therapy.
- Orthotic Devices.
- Home health care (no more than 100 home health care visits in any period of 12 consecutive months).
- Preventive Care without copayments, coinsurance or deductible as described under Federal law and regulation regarding preventive services. This includes:
  1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force including smoking and tobacco cessation counseling and domestic violence and screening counseling;
  2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  3. with respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration including gonorrhea prophylactic medication, Hypothyroidism screening, PKU screening, RH incompatibility screening and routine hearing screening;
  4. with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and includes contraceptive drugs and devices;
  5. with respect to mammography screening including coverage of screening by low-dose mammography for all women over 35; (1) Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older; (2) For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered medically necessary; (3) Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described. (4) Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit. (5) When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the policy;
  6. benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology;
  7. coverage for a vaccine for shingles that is approved for marketing by the federal Food and Drug Administration if the vaccine is ordered by a Physician licensed to practice medicine in all its branches and the enrollee is 60 years of age or older;
  8. coverage for a human papillomavirus vaccine (HPV) that is approved for marketing by the federal Food and Drug Administration;
  9. coverage for all of the following: 1) An annual cervical smear or pap smear test for female insureds; 2). An annual digital rectal examination and a prostate-specific antigen test, for male insureds upon the recommendation of a Physician licensed to practice medicine in all its branches for: a). asymptomatic men age 50 and over; b). African-American men age 40 and over; and c). men age 40 and over with a family history of prostate cancer; 3) Surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer.
- Recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. Pediatric dental care (Covered Persons under age 19). This includes preventive, basic and restorative dental care. Also orthodontic treatment including braces (once per lifetime). See policy for specific details.
- Pediatric vision care (Covered Persons under age 19). This includes an annual eye exam and one (1) pair of glasses (frames and lenses) per year. See policy for specific details.
- Inpatient Bariatric Surgery.
- Hearing Aid benefit for bone anchored hearing aids. [The benefit is limited to 2 hearing aids every 3 years.
- Temporomandibular Joint Disorders (TMJ): covers services including medical care or services to treat dysfunction or TMJ resulting from a medical cause or Injury; Office visits for medical evaluation and Treatment; X-rays of the TMJ including contrast studies, but not dental x-rays; and Myofunctional therapy and surgery to the TMJ, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.
- Mastectomy and Reconstructive surgery following breast cancer in compliance with the Women’s Health and Cancer Rights Act of 1998.
- Infertility Treatment.
- Emergency Medical Care – Criminal Sexual Assault: Benefits will be provided for charges for testing and examination for victims of criminal sexual assault. Covered at 100% with no cost sharing.
- Autism Spectrum Disorder: Benefits for the diagnosis and treatment of Autism Spectrum Disorder are the same as benefits for any other condition and will be provided without regard to the Covered Person’s age. Treatment for Autism Spectrum Disorder shall include the following care when prescribed, provided or ordered for an individual diagnosed with Autism Spectrum Disorder by a Physician or a Psychologist who has determined that such care is medically necessary, or, a certified, registered, or licensed health care professional with expertise in treating Autism Spectrum Disorder and when such care is determined to be medically necessary and ordered by a Physician or a Psychologist:
  1. Psychiatric care, including diagnostic services
  2. Psychological assessments and treatments
  3. Habilitative or rehabilitative treatments
  4. Therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: self care and feeding, pragmatic, receptive and expressive language, cognitive functioning, applied behavioral analysis (ABA), intervention and modification, motor planning and sensory processing.
- Eye Drops: Coverage for the refill of a prescription for topical eye medication when: 1). the medication is to treat a chronic condition of the eye; 2). the refill is requested by the Covered Person prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and 3). the prescribing Physician

licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the Covered Person do not exceed the total number of refills prescribed.

- Opioid Antagonist: Coverage for at least one opioid antagonist, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the opioid antagonist. This coverage must include refills for expired or utilized opioid antagonists. "Opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.
- Cancer Medications: Benefits will be provided for orally administered cancer medications, intravenously administered cancer medications or injected cancer medications that are used to kill or slow the growth of cancerous cells. The financial requirements and treatment limitations applicable to orally-administered cancer medications will be no more restrictive than those same requirements applied to intravenously administered or injected cancer medications.
- Diabetes Self-Management Training and Education: Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy prescribed by a Physician or duly certified registered or licensed health care professional with expertise in diabetes management. Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

BENEFIT LIMITATIONS: MEDICAL EXPENSES

- Payment for Hospital room and board, which including all general nursing charges, will be limited to the Hospital's normal charge for semi-private accommodation. Intensive Care Unit charges will be limited to two times the semi-private room and board rate per day.
- Dental Treatment is limited as follows: (a) services must be performed by a Physician; and (b) treatment must be Medically Necessary by Injury to sound, natural teeth. Routine dental care and treatment to the gums are not covered, except for pediatric dental care.
- Benefits for Treatment of Injuries sustained by reason of participation in or, practice for intercollegiate sports are limited to a maximum of $5,000 per Injury.

EXPRESS SCRIPTS

The Policy utilizes the Express Scripts Pharmacy network. The medical ID Card includes information the pharmacist needs in order to submit a claim. Although many pharmacies participate in the Express Scripts, Inc. network, check with the pharmacy before you make your purchase. To find participating pharmacies in your area, call Express Scripts, Inc. at 1-866-282-1491 or visit their website at www.express-scripts.com. You will not have to file a claim on purchases made at participating pharmacies. The plan utilizes Express Scripts Prescription Benefit Manager's Formulary. Certain prescription drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded prescriptions. The pharmacist will tell you exactly what to pay.

PREFERRED PROVIDER NETWORK (Within the United States only)

The Policy utilizes the PHCS hospital and physician network for the purpose of delivering health care. Call 1-800-922-4362 or visit www.multiplan.com to find a PHCS provider, or if none are available, a MultiPlan provider.

In-network means Physicians, Hospitals or other health care providers who have contracted to provide medical care at negotiated prices. The availability of providers is subject to change without notice. A Covered Person should always confirm that a provider is an in-network provider at the time services are provided or when making an appointment.

Out-of-network means providers who have not agreed to any pre-arranged fees. If a Covered Person seeks treatment from an out-of-network provider, benefits will be paid at the out-of-network levels shown in the Description of Benefits. A Covered Person will incur potentially significant out-of-pocket expenses when using these out-of-network providers.

POLICY EXCLUSIONS

Benefits not payable under the Policy in the following circumstances:

1. Adult eye examinations; prescriptions or fitting of eyeglasses and contact lenses; eyeglasses, contact lenses or other Treatment for visual defects and problems, except as required as a result of a covered Injury or for Pediatric Vision Care. "Visual defects" means any physical defect of the eye that does or can impair normal vision.
2. Hearing examinations or hearing aids; or other Treatment for hearing defects and problems except as provided under the Preventive Services Benefit of the Policy or as required as a result of a covered Injury. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing.
3. Dental care or Treatment except as otherwise provided under the Policy.
4. War or any act of war, declared or undeclared; or while serving in the armed forces of any country (a pro-rata premium will be refunded for such period of service).
5. Participation in a riot or civil disorder; commission of or attempt to commit a felony.
6. Expenses for Treatment of Injuries sustained by reason of participation in or, practice for; intercollegiate sports except as otherwise noted; semi-professional sports; or professional sports.
7. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any type of aircraft, except while riding as a fare-paying passenger on a regularly-scheduled airline.
8. Treatment, services or supplies provided by a Hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a Hospital which does not unconditionally require payment.
9. Cosmetic surgery, except cosmetic surgery which the Covered Person needs as the result of an Accident which happens while such person is insured under the Policy or reconstructive surgery needed as a result of a congenital disease or abnormality of a covered newborn, adoptive and foster dependent child (including, but not limited to cleft lip or cleft palate), which has resulted in a functional defect.
10. Elective Treatments and voluntary testing except as otherwise provided under the Policy.
11. Injury or Sickness covered by Worker's Compensation or Employer's Liability Laws or similar legislation.
12. Charges used to meet any Deductible, or in excess of the Coinsurance level, or in excess of those considered Allowable Charges.
13. Treatment or services provided by any member of the Covered Person's immediate family; or for which no charge is normally made.
14. Treatment, services or supplies provided normally without charge by the School's infirmary or its employees, or Physicians who work for the School.
15. Rest cures or custodial care (whether or not prescribed by a Physician), or transportation.
16. Treatment, services or supplies provided or paid for by any governmental program or law, except Medicaid.
17. Nasal or Sinus Surgery or surgery to correct a deviated nasal septum (unless required due to an Injury resulting from an Accident while the Covered Person is insured under the Policy).
18. Acupuncture.
19. For international students only, Expenses incurred within the Covered Person's home country or country of regular domicile.
20. Treatment that is not incurred by a Covered Person while insured hereunder.
21. Circumcision.

22. Routine foot care including the Treatment of corns, calluses and bunions.
23. Nonmalignant warts, moles or lesions.
24. Applied behavioral analysis except as otherwise provided in the Policy.
25. Biofeedback, neuro feedback and related testing.
26. Donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate blood related family members.
27. Educational, vocational or self-management training services or supplies unless otherwise provided in the Policy or when received as a part of a covered wellness visit or screening.
28. Experimental or investigational procedures except as otherwise provided in the Policy.
29. Group speech therapy.
30. Health club memberships, health spa charges, exercise equipment or classes, charges from a physical fitness instructor or personal trainer, or any other charges for services, equipment or facilities for developing or maintaining physical fitness, even when ordered by a Physician.
31. Home care services, including homemaker services; maintenance therapy; food and home delivered meals; or custodial care and services.
32. Certain Hospital services, including guest meals, telephones, televisions and other convenience items; care by interns, house Physicians or other Hospital employees billed separately, private room unless Medically Necessary.
33. Immunizations for travel and work or when not received as a part of the Preventive Care Services Benefit.
34. Mental health and substance use disorder services not covered include: Inpatient stays for environmental changes; cognitive rehabilitation therapy; educational therapy; vocational and recreational activities; coma stimulation therapy; services, surgery, and drugs to treat deviation and dysfunction; Treatment of social maladjustment without signs of psychiatric disorder; or remedial or special education services.
35. Medical nutritional therapy (obesity); nutritional counseling, except when provided as a part of diabetes education or when received as part of wellness services visit or screening; nutritional and/or dietary supplements except as required by law. This exclusion includes but is not limited to nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription.
36. Over-the counter convenience and hygienic items.
37. Recreation therapy including sleep, dance, arts, crafts, aquatic, gambling and nature therapy.
38. Services or supplies for or related to sex transformation.
39. Skilled Nursing Facility stays for Treatment of psychiatric conditions and senile deterioration; Inpatient services during a temporary leave from a Skilled Nursing Facility; or a private room unless Medically Necessary.
40. Appliances for temporomandibular joint pain dysfunction.
41. Services or supplies related to immune gamma globulin therapy.

DEFINITIONS

Wherever used in the Policy:

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

Allowable Charges means the lesser of the negotiated fee or the provider's actual charges for care and Treatment. If there is no negotiated fee the Allowable Charges for care and Treatment are the lesser of the provider’s fee for the actual service or the Usual, Reasonable and Customary Charge.

Coinsurance means the portion of Allowable Charges that the Insured has to pay.

Complications of Pregnancy means any condition which: (1) is diagnosed as being distinct from pregnancy but is adversely affected by or caused by pregnancy and (2) requires a Hospital stay. Such conditions include: acute nephritis, nephrosis, cardiac decompression, missed abortion, ectopic pregnancy, spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible, a non-elective cesarean section and similar medical and surgical conditions of comparable severity.

Co-payment means a specified charge that the Covered Person is required to pay when a medical service is rendered.

Covered Person means any 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.

Deductible means the amount of Allowable Charges the Insured owes before We begin to pay for Covered Expenses.

Emergency Care means bona fide emergency services provided in:

a) a Hospital emergency room after the sudden onset of a medical condition resulting from an Injury or Sickness manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably expect to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of a bodily organ or part; or
b) an urgent care facility, instead of a Hospital emergency room, when You need immediate care after the sudden onset of a medical condition resulting from a non-life threatening Injury or Sickness that require care within 48 hours of onset to limit severity and prevent complications.

Essential Health Benefits means benefits covered under the policy, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the PPACA and any regulations issued pursuant thereto. Essential Health Benefits are not subject to annual or lifetime dollar limits.

Hospital means a legally constituted institution having organized facilities for the care and Treatment of sick or injured persons on a registered Inpatient basis provided under the supervision of a staff or one or more licensed Physicians and provides 24-hour nursing service by Registered Nurses on duty or call.

Injury means accidental bodily harm sustained by the Covered Person that resulted directly and independently of all other causes from an Accident and occurs while coverage under the Policy is in force.

Inpatient means confinement for which the Covered Person is charged at least one full day's room and board.

Medically Necessary means services or supplies that are (1) provided for the diagnosis, Treatment, cure or relief of a health condition, Sickness, Injury or disease; and, except as allowed under a covered clinical trial, not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, Treatment, cure, or relief of a health condition, Sickness, Injury, disease, or its symptoms; (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the Covered Person, the Covered Person’s family or the provider.

For Medically Necessary services or supplies, nothing in this definition precludes Our comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Non-Preferred Provider means a licensed provider of medical services who is not under agreement with the PHCS hospital and physician network to provide those services. A Covered Person may be confined in a Hospital that is a Non-Preferred Provider. If such person can be transferred to a Hospital which is a Preferred Provider, without

affecting the quality of care, and elects to so transfer, benefits will become payable at the Preferred Provider rate from the transfer date.

Preferred Provider means a licensed provider of medical services who is under agreement with the PHCS hospital and physician network to provide those services. A list of Preferred Providers will be provided to the Policyholder, when applicable.

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 he works, and who is practicing within the scope and limitation of that license. The term Nurse will not include the Covered Person or his spouse, children, brothers, sisters, or parents, or any person residing in his household.

Registered Nurse means a person who has received the designation of "Registered Nurse (R.N.)" and is registered and licensed to practice by the State Board of Nurse Examiners or other state authority in the state where such person works, and who is practicing within the scope and limitation of that license. The term Registered Nurse will not include the Covered Person or such person's spouse, children, brothers, sisters, or parents, or any person residing in such person's household.

Oral Surgery means oral surgery for: maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is Medically Necessary to attain functional capacity of the part; surgical services on the hard or soft tissue of the mouth when the main purpose is not to treat or help the teeth and supporting structures; and the Treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.

Outpatient Surgical Facility means a surgical or medical center, which 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.

Patient Protection and Affordable Care Act means the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act (Public Law 111-152).

Physician means a practitioner of the healing arts who is duly licensed in the state where he is practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person or his spouse, children, brothers, sisters, or parents, or any person residing in his household.

Sickness means illness or disease contracted and causing loss as to the Covered Person whose Sickness is the basis of claim. The term Sickness also includes Complications of Pregnancy.

Skilled Nursing Facility means a facility which is licensed pursuant to state and local laws; is operated primarily for the purpose of providing skilled nursing care and Treatment for individuals convalescing from Injury or Sickness including room and board and provides 24 hour a day skilled nursing services under the full time supervision of a Physician or Registered Nurse and if full time supervision by a Physician is not provided has , it has the services of a Physician available under a fixed agreement; it keeps adequate medical records and has organized facilities for medical Treatment. Skilled Nursing Facility does not include an institution or part of one that is used mainly as a place for rest or the aged.

Temporomandibular Joint Disorders (TMJ) means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.

Treatment means a specific in-office or Hospital physical examination of, or care rendered to, the Covered Person.

Usual, Customary, and Reasonable Charges - "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 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 Sirius America Insurance Company.

COORDINATION OF BENEFITS PROVISION

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

SUBROGATION

We are assigned the right to recover from the negligent third party, or his or her Insurer, to the extent of the benefits we paid for that sickness or injury. The Covered Person is required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

CONFORMITY WITH STATUTES

Any provision that is in conflict with the requirements of state or federal law that applies to the Policy are automatically changed to satisfy the minimum requirements of such laws.

For benefit and claim questions, or to request an ID Card please contact the claims' administrator:

ASRM, LLC
505 South Lenola Road, Suite 231
Moorestown, NJ 08057

TOLL FREE 800-359-7475
FAX 856-231-7995
WEB .... www.helpwithmyplan.com
EMAIL .... customerservice@asrmllc.com

Servicing agent and contact information:

Associated Insurance Plans International, Inc.
13351 S. German Road
Post Office Box 67
Bruce Crossing, MI 49912-0067

TOLL FREE 800-452-5772
WEB .... www.MyUSFInsurance.com

europ assistance
you live we care

Travel Assistance Services

Your Guide to Safe Travel

Emergencies happen, but help is now only a phone call away.

An unexpected illness, tooth ache or forgotten medication can ruin a trip. With travel assistance services from Europ Assistance USA (EA), help is only a phone call away. When you are traveling you have access to travel medical and personal services.

With a local presence in 200 countries and territories worldwide and 35 24/7 assistance centers staffed with multilingual assistance coordinators and case managers as well as medical and security staff, EA is here to help you obtain the care and attention you need in case of an emergency while traveling.

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance, and then contact EA.

Medical Assistance Services

- Emergency Medical Payment
- Medical Search and Referral
- Replacement of Medication and Eyeglasses
- Medical Monitoring
- Visit by Family Member or Friend
- Dependent Children Assistance
- Traveling Companion Assistance
- Emergency Evacuation/Medically-Necessary Repatriation
- Repatriation of Mortal Remains
- Trip Interruption

Personal Assistance Services

- Pre-Trip Information
- Interpretation/Translation
- Locating Lost or Stolen Items
- Emergency Cash
- Emergency Travel Arrangements
- Legal Assistance/Bail
- Emergency Message Relay
- Vehicle Return
- Pet Return

Contact Us for Help 24/7

240-330-1536
(Collect outside the US)

877-319-4387
(Toll-free in the US and Canada)

ops@europassistance-usa.com

Scan the QR code with your smartphone to automatically add Europ Assistance to your contacts

When you call, please be ready to provide:
** The name of your company
** A phone number where we may reach you

See reverse for detailed service information

This is a non-contractual document.
TA Flyer 12571_0312

Travel Assistance Services Details

Medical Assistance Services

Emergency Medical Payment
EA will advance on-site emergency inpatient medical payments to you, up to $10,000 USD upon receipt of satisfactory guarantee of reimbursement from you. The cost of medical services is your responsibility.

Medical Search and Referral
EA will assist you in finding physicians, dentists and medical facilities.

Replacement of Medication and Eyeglasses
EA will arrange to fill a prescription that has been lost, forgotten, or requires a refill, subject to local law, whenever possible. EA will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Medical Monitoring
During the course of a medical emergency resulting from an accident or sickness, professional case managers, including physicians and nurses, EA will monitor your case to determine whether the care is appropriate.

Visit by Family Member/Friend
If you are traveling alone and must be or are likely to be hospitalized for seven or more days or are in life-threatening condition, EA will arrange and coordinate payment for the round-trip transportation for one family member or friend, designated by you from his or her home to the place where you are hospitalized.

Dependent Children Assistance
If any dependent children under the age of 19 traveling with you are left unattended because you are hospitalized, EA will coordinate their transportation home. Should transportation with an attendant be necessary, EA will arrange for a qualified escort to accompany the child(ren). All costs related to this service are your responsibility.

Traveling Companion Assistance
If a travel companion loses previously-made travel arrangements due to your medical emergency, EA will arrange for your traveling companion's return home. Transportation costs are the responsibility of you or your traveling companion.

Emergency Evacuation/Medically-Necessary Repatriation
In the event of a medical emergency, when a physician designated by EA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, EA will coordinate and arrange payment for the transport under proper medical supervision.

Repatriation of Mortal Remains
In the event of your death while traveling, EA will coordinate and arrange payment for all necessary government authorization, including a container appropriate for transportation and for the return of the remains to place of residence for burial.

Trip Interruption
If you or an immediate family member is critically injured, sick or dies while traveling, EA shall arrange for you or your immediate family member's return to the preferred place of hospitalization or burial via the most direct route on economy class airfare. Transportation cost is your responsibility.

Personal Assistance Services

Pre-Trip Information
EA offers a wide range of informational services before you leave home, including: Visa, Passport, Heath Hazards Advisories, Currency Exchange, Inoculation and Immunization Requirements, Temperature and Weather Conditions and Embassy and Consulate Referrals.

Interpretation/Translation
EA will assist with telephone interpretation in all major languages. If you require ongoing or more complex translation services, EA will refer you to local translators.

Locating Lost or Stolen Items
EA will assist in locating and replacing lost luggage, transportation ticket application, documents and personal possessions.

Emergency Cash
EA will advance up to $500 after satisfactory guarantee of reimbursement from you. Any fees associated with the transfer or delivery of funds are your responsibility.

Emergency Travel Arrangements
In the event of an emergency, EA can help you make new travel arrangements, including airline, hotel and car rental reservations. All costs related to this service are your responsibility.

Legal Assistance/Bail
EA will notify the proper embassy or consulate of incarceration, arranging the receipt of funds from third party sources and locate an attorney and bail bonds, where permitted by law, with satisfactory guarantee of reimbursement from you. You pay attorney fees.

Emergency Message Relay
EA will transmit an urgent message for you to your family, friends or business associates. EA will also accept and retain messages for up to 15 days.

Vehicle Return
EA will coordinate the return of the vehicle left unattended to your residence or place of rental if you become physically unable to operate any non-commercial vehicle as a result of a medical emergency. The vehicle must be in good driving condition and capable of being driven on the highway in compliance with local laws. All costs related to this service are your responsibility.

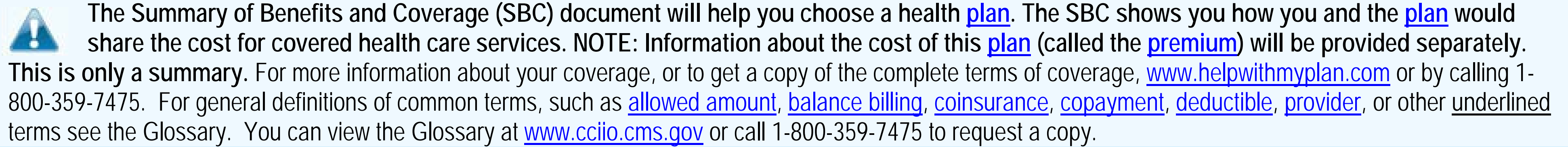
Pet Return
EA will coordinate the return to your residence if a pet traveling with you is left unattended because you are hospitalized. All costs related to this service are your responsibility.

Conditions and Exclusions
EA USA shall provide services to all members. On any expenditure for which the member is responsible, EA shall not be obligated to provide services without first securing funds from the member in payment of such expenditure. If the member pays for covered expenses without receiving an approval or authorization in writing from EA, then EA shall not be obligated to reimburse the member for any such expenditure. In the event a member requests a service not included in a program, EA may, in its sole and absolute discretion, provide such benefits or services at the sole expense of the member, including a reasonable fee to EA for its efforts on behalf of the member.

EA provides the services under this program in all countries of the world. However, conditions such as war, natural disaster or political instability may exist in some countries that render assistance services difficult or impossible to provide. In such instances services cannot always be assured. EA shall attempt to assist a member consistent with the limitations presented by the prevailing situation in the area. EA reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit EA to fully provide services. In the event a member travels in any area in which such conditions exist, EA nonetheless shall endeavor to provide services consistent, however, with the risks and conditions then prevailing. EA shall not be responsible for failure to provide, or for delay in providing services when such failure or delay is caused by conditions beyond EA's control, including but not limited to flight conditions, labor disturbance and strike, rebellion, riot, civil commotion, war or uprising, nuclear accidents, natural disasters, acts of God or where rendering a service is prohibited by local law or regulations.

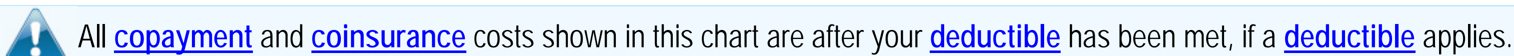
Decisions by physicians or other health care professionals employed by or under contract to or designated by EA as to the medical necessity for providing any of the medical services covered by this program are medical decisions based on medical factors and shall be conclusive in determining the need for such services. EA shall not evacuate or repatriate a member if an EA designated physician determines that such transport is not medically advisable or necessary or if the injury or illness can be treated locally. In all cases, the medical professionals, medical facilities or legal counsel suggested by EA to provide direct services to the eligible person pursuant to this program are not employees or agents of EA, and the final selection of any such medical professional, medical facility, or legal counsel is your choice alone. EA assumes no responsibility for the quality or content of any such medical or legal advice or services. EA shall not be liable for the negligence or other wrongful acts or omissions of any of the healthcare or legal professionals providing direct services arising out of or pursuant to this program. The member shall not have any recourse against EA by reason of its suggestion of or contract with any medical professional or attorney.

These services are not insured benefits. To the extent these services or any advanced payments are not included in the program, you will be responsible for payment. All services must be arranged by and approved by EA.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.helpwithmyplan.com or by calling 1-800-359-7475. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-359-7475 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $100/per person Out-of-Network: $100/per person	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services and in-Network care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,600/individual Out-of-Network: $14,300/individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com or call 1-800-922-4362 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ Immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$25 copay/prescription	$25 copay/prescription	Covers up to a 30-day supply (retail prescription)
	Preferred brand drugs	$50 copay/prescription	$50 copay/prescription	
	Non-preferred brand drugs	$50 copay/prescription	$50 copay/prescription	
	Specialty drugs	$50 copay/prescription	$50 copay/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit and 20% coinsurance	$250 copay/visit and 20% coinsurance	The Copay/per visit will be waived if admitted to the Hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$75 copay/visit and 20% coinsurance	$75 copay/visit and 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.helpwithmyplan.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/in any 12 months
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visits/year
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day per admission. Benefits renew after 108 days without care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Must be primarily and customarily used to serve a medical purpose; can withstand repeated use; and generally is not useful to the person in the absence of Injury or Sickness
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Coverage limited to one exam/year.
	Children's glasses	20% coinsurance	40% coinsurance	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	40% coinsurance	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Care within an International Student's home country or country of regular domicile
- Hearing aids (Adult)
- Long-term care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

* For more information about limitations and exceptions, see the plan or policy document at www.helpwithmyplan.com.]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Sirius America Insurance Company at 1-844-312-4357.
- ASRM, LLC (Claims Administrator) at 1-800-859-7475
- Additionally, a consumer assistance program can help you file your appeal. Contact the Delaware Department of Insurance at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.helpwithmyplan.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist *(Copayment)*	$0
Hospital (facility) *(Co-insurance)*	20%
Other *(Co-insurance)*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$22,500

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$4,480
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,580**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist *(total co-payment amount)*	$0
Hospital (facility)	0%
Other *(Co-insurance)*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$3,000

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$580
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$680**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist *(Copayment)*	$0
Hospital (facility)	20%
Other *(Co-insurance)*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$6,500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.