



# World Class Coverage Plan

*designed for*

## Wheaton College Study Abroad Participants

### 2011 - 2012

*administered by* Cultural Insurance Services International • River Plaza • 9 West Broad Street • Stamford, CT 06902-3788  
*This plan is underwritten by* The Insurance Company of the State of Pennsylvania, a member Chartis Insurance

*Policy terms and conditions are briefly outlined in this Description of Coverage. Complete provisions pertaining to this insurance are contained in the Master Policy on file with the trustee, Group Insurance Trust, Washington, D.C., and the Participating Organization. In the event of any conflict between this Description of Coverage and the Master Policy, the Policy will govern*

Schedule of Benefits Coverage and Services	Policy # <i>GLB 9111696</i> Maximum Limits
<b>Section I</b>	
• Accidental Death Per Insured	\$15,000
• Medical expenses (per Accident or Sickness):	
Deductible	\$50
Basic Medical	\$100,000 at 100%
• Extension of Benefits	30 days
• Emergency Medical Reunion	\$1,000
• Home Country Coverage	\$5,000
<b>Section II</b>	
• Medical Evacuation	\$100,000
• Return of Mortal Remains	\$50,000
<b>Section III</b>	
• Security Evacuation (comprehensive)	\$100,000
• Team Assist # GLB 9111696	

### Section I - Benefit Provisions

Benefits are payable under this Policy for Covered Expenses incurred by an Insured Person for the items stated in the Schedule of Benefits. Benefits shall be payable to either the Insured Person or the Service Provider for Covered Expenses incurred Worldwide. The first such expense must be incurred by an Insured within 30 days after the date of the Accident or commencement of the Sickness; and:

- All expenses must be incurred by the Insured within 52 weeks from the date of the Accident or commencement of the Sickness; and
- The Insured must remain continuously insured under the Policy for the duration of the treatment.

The charges enumerated herein shall in no event include any amount of such charges which are in excess of Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount shall not be recognized as a Covered Expense. All charges shall be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

### Extension of Benefits:

Your coverage will be extended if You are Hospital confined for a Covered Injury or Illness and under the care of a Physician on the termination date of Your Period of Coverage. Coverage will terminate on the earlier of the following:

- 1) 30 days from the end of Your Period of Coverage; or
- 2) The maximum benefit has been paid; or
- 3) Your release from the Hospital or Physician care.

### Accidental Death and Dismemberment Benefit

**Accidental Death Benefit.** If Injury to the Insured results in death within 365 days of the date of the accident that caused the Injury, the Company will pay 100% of the Maximum Amount.

**Accidental Dismemberment Benefit.** If Injury to the Insured results, within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Maximum Amount shown below for that Loss:

For Loss of:	Percentage of Maximum Amount
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid. Only one benefit, the largest to which you are entitled, is payable for all losses resulting

from the same accident. Maximum aggregate benefit per occurrence is \$1,000,000.

### **Accident and Sickness Medical Expenses**

The Company will pay Covered Expenses due to Accident or Sickness only, as per the limits stated in the Schedule of Benefits. Coverage is limited to Covered Expenses incurred subject to Exclusions. All bodily Injuries sustained in any one Accident shall be considered one Disablement, all bodily disorders existing simultaneously which are due to the same or related causes shall be considered one Disablement. If a Disablement is due to causes which are the same or related to the cause of a prior Disablement (including complications arising there from), the Disablement shall be considered a continuation of the prior Disablement and not a separate Disablement.

Treatment of an Injury or Illness must occur within 30 days of the Accident or onset of the Illness.

When a covered Injury or illness is incurred by the Insured Person the Company will pay Reasonable and Customary medical expenses excess of the Deductible and Coinsurance as stated in the Schedule of Benefits. In no event shall the Company's maximum liability exceed the maximum stated in the Schedule of Benefits as to Covered Expenses during any one period of individual coverage.

### **Covered Accident and Sickness Medical Expenses**

*For the purpose of this section, only such expenses, incurred as the result of a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in the Exclusions section, shall be considered as Covered Expenses:*

- Charges made by a Hospital for room and board, floor nursing and other services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation
- Charges made for Intensive Care of Coronary Care charges and nursing services
- Charges made for diagnosis, treatment and Surgery by a Physician
  - Charges made for an operating room
  - Charges made for Outpatient treatment, same as any other treatment covered on an Inpatient basis. This includes ambulatory Surgical centers, Physicians' Outpatient visits/examinations, clinic care, and Surgical opinion consultations.
  - Charges made for the cost and administration of anesthetics.
  - Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, iron lungs, and medical treatment
  - Charges for physiotherapy, if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed physiotherapist
    - Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon
    - Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items
    - Local transportation to or from the nearest Hospital or to and from the nearest Hospital with facilities for required treatment. Such transportation shall be by licensed ground ambulance only
    - Nervous or Mental Disorders: are payable, a) up to \$500 for outpatient treatment; or b) up to \$2,500 on an inpatient basis. The Company shall not be liable for more than one such inpatient or

outpatient occurrence per lifetime under the Policy with respect to any one Insured

- Chiropractic Care and Therapeutic Services shall be limited to a total of \$50 per visit, excluding x-ray and evaluation charges, with a maximum of 10 visits per injury or illness. The overall maximum coverage per injury or illness is \$500.00 which includes x-ray and evaluation charges.
- With respect to Accidental Dental, an eligible Dental condition shall mean emergency dental repair or replacement to sound, natural teeth damaged as a result of a covered Accidents.
- Expenses incurred within the Insured Person's home country or country of regular domicile are payable up to \$5,000.

### **Extension of Benefits**

Medical benefits are automatically extended 30 days after expiration of Insurance for conditions first diagnosed or treated during or related to your overseas study program with Wheaton College. Benefits will cease 12:01 a.m. on the 31st day following termination of Insurance.

### **Emergency Medical Reunion**

When an Insured Person is hospitalized for more than six days, the Company will arrange and pay for round trip economy-class transportation for one individual selected by the Insured Person, from the Insured Person's current Home Country to the location where the Insured Person is hospitalized. The benefits payable will include:

- The cost of a round trip economy airfare and their hotel and meals (to a maximum of \$75 per day) up to the maximum stated in the Schedule of Benefits, Emergency Medical Reunion;
- All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an assistance company representative appointed by the Company.

### **Exclusions**

*For all benefits listed in the Schedule of Benefits this Insurance does not cover:*

- Pre-Existing conditions, defined as any condition for which a licensed Physician was consulted, or for which treatment or medication was prescribed, or for which manifestations of symptoms would have caused a person to seek medical advice prior to the Effective Date of coverage under the Policy, except as specified below:

If the Insured Person does not receive medical care or services, including prescription drugs or other medical supplies, and is not under the care of a Physician with respect to the Pre-Existing Condition or related condition(s), for a period of 12 consecutive months beginning on or after the first day of coverage, the preexisting condition exclusion will no longer apply and any eligible charges incurred after the treatment free period will be considered for reimbursement; or

If the Injured Person is covered under the Policy for 12 consecutive months, the Pre-Existing Condition exclusion will no longer apply and any eligible expenses incurred thereafter will be considered for reimbursement; or

Emergency Medical Evacuation/Repatriation and Return of Mortal Remains

**Note: This policy does pay benefits to a maximum of \$1,500 for loss due to a pre-existing condition.**

- Charges for treatment which exceed Reasonable and Customary charges
- Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes

- Services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified as Medically Necessary and reasonable by a Physician
- Suicide or any attempt thereof, while sane or self destruction or any attempt thereof, while sane
- Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with a) war, invasion, warlike operations (whether war be declared or not), or civil war; or b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power
  - Injury sustained while participating in professional athletics
  - Routine physicals, immunizations, or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations, except in the course of a Disablement established by a prior call or attendance of a Physician
  - Treatment of the Temporomandibular joint
  - Vocational, speech, recreational or music therapy
  - Services or supplies performed or provided by a Relative of the Insured Person, or anyone who lives with the Insured Person
  - The refusal of a Physician or Hospital to make all medical reports and records available to the Company will cause an otherwise valid claim to be denied
  - Cosmetic or plastic Surgery, except as the result of a covered Accident; for the purposes of this Policy, treatment of a deviated nasal septum shall be considered a cosmetic condition
  - Elective Surgery or Elective Treatment which can be postponed until the Insured Person returns to his/her Home Country, where the objective of the trip is to seek medical advice, treatment or Surgery
    - Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids
    - Eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by Accidental bodily Injury incurred while insured hereunder
    - Any Mental and Nervous disorders or rest cures, unless otherwise covered under this Policy
    - Treatment while confined primarily to receive custodial care, educational or rehabilitative care, or nursing services
    - Congenital abnormalities and conditions arising out of or resulting therefrom
    - The cost of the Insured Person's unused airline ticket for the transportation back to the Insured Person's Home Country, where an Emergency Medical Evacuation or Repatriation and/or Return of Mortal Remains benefit is provided
    - Expenses as a result or in connection with intentionally self-inflicted Injury or Illness
    - Expenses as a result or in connection with the commission of a felony offense
    - Injury sustained while taking part in mountaineering where ropes or guides are normally used; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; parasailing
    - Treatment paid for or furnished under any other individual or group policy or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for treatment without cost to any individual

- Injuries for which benefits are payable under any no-fault automobile Insurance Policy
  - Dental care, except as the result of Injury to natural teeth caused by Accident, unless otherwise covered under this Policy
  - Routine Dental Treatment
  - Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof, or abortion limited to \$500
  - Treatment for human organ tissue transplants and their related treatment
  - Expenses incurred within the Insured Person's home country or country of residence, unless otherwise covered under this Policy
    - Weak, strained or flat feet, corns, calluses, or toenails
    - Diagnosis and treatment of acne
    - Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft.

*In addition to the exclusions listed above, the following exclusions apply to Accidental Death and Dismemberment Insurance only:*

- Disease of any kind
- Bacterial infections except pyogenic infection which shall occur through an accidental cut or wound
  - Neuroses, psychoneuroses, psychopathies, psychoses or mental or emotional diseases or disorders of any type.

## Subrogation

To the extent the Company pays for a loss suffered by an Insured, the Company will take over the rights and remedies the Insured had relating to the loss. This is known as subrogation. The Insured must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over an Insured's rights, the Insured must sign an appropriate subrogation form supplied by the Company.

## Definitions

**Accident or Accidental** means an event, independent of Illness or self inflicted means, which is the direct cause of bodily Injury to an Insured Person.

**Coinsurance** means the percentage amount of eligible Covered Expenses, after the Deductible, which are the responsibilities of the Insured Person and must be paid by the Insured Person. The Coinsurance amount is stated in the Schedule of Benefits, under each stated benefit.

**Company** shall be The Insurance Company of The State of Pennsylvania.

**Covered Expenses** means expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and which do not exceed the maximum limits shown in the Schedule of Benefits, under each stated benefit.

**Deductible** means the amount of eligible Covered Expenses which are the responsibility of each Insured Person and must be paid by each Insured Person before benefits under the Policy are payable by the Company. The Deductible amount is stated in the Schedule of Benefits, under each stated benefit.

**Disablement** as used with respect to medical expenses means an illness or an Accidental bodily Injury necessitating medical treatment by as a Physician defined in this Policy.

**Effective Date** means the date the Insured's Persons coverage under this Policy begins. The Effective Date of this Policy is the later of the following:

1. The Date the Company receives a completed Application and premium for the Policy Period or
2. The Effective Date requested on the Application or
3. The Date the Company approves the Application

**Elective Surgery or Elective Treatment** means surgery or medical treatment which is not necessitated by a pathological or traumatic change in the function or structure in any part of the body first occurring after the Insured's effective date of coverage. Elective Surgery includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, and submucous resection and/or other surgical correction for deviated nasal septum, other than for necessary treatment of covered purulent sinusitis. Elective Surgery does not apply to cosmetic surgery required to correct a covered Accident. Elective Treatment includes, but is not limited to, treatment for acne, nonmalignant warts and moles, weight reduction, infertility, learning disabilities.

**Eligible Benefits** means benefits payable by the Company to reimburse expenses which are for Medically Necessary services, supplies, care, or treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary charges; incurred while insured under this Policy; and which do not exceed the maximum limits shown in the Schedule of Benefits under each stated benefit.

**Emergency** means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within 24 hours.

**Family Member** means a spouse, parent, sibling or Child of the Insured Person.

**Home Country** means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

**Hospital** as used in this Policy means except as may otherwise be provided, a Hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or Injured persons with organized facilities for diagnosis and Surgery and having 24-hour nursing service and medical supervision.

**Illness** wherever used in this Policy means sickness or disease of any kind contracted and commencing after the Effective Date of this Policy and Disablement covered by this Policy.

**Injury** wherever used in this Policy means bodily Injury caused solely and directly by violent, Accidental, external, and visible means occurring while this Policy is in force and resulting directly and independently of all other causes in Disablement covered by this Policy.

**Insured Person(s)** means a person eligible for coverage under the Policy as defined in "Eligible Persons" who has applied for coverage and is named on the application and for whom the company has accepted premium. This may be the Primary Insured Person or Dependent(s).

**Medically Necessary or Medical Necessity** means services and supplies received while insured that are determined by the Company to be: 1) appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Insured Person's medical conditions; 2) within the standards the organized medical community deems good medical practice for the Insured Person's condition; 3) not primarily for the convenience of the Insured Person, the Insured Person's Physician or another Service Provider or person; 4) not Experimental/Investigational or unproven, as recognized by the organized medical community, or which are used for any type of research program or protocol; and 5) not excessive in scope, duration, or intensity to provide safe and adequate, and appropriate treatment.

**Mental and Nervous Disorder** means a Sickness that is a mental, emotional or behavioral disorder.

**Permanent Residence** means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

**Physician** as used in this Policy means a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

**Pre-existing Condition** for the purposes of this Policy means 1) a condition that would have caused person to seek medical advise, diagnosis, care or treatment during the 180 days prior to the Effective Date of coverage under this Policy; 2) a condition for which medical advise, diagnosis, care or treatment was recommended or received during the 180 days prior to the Effective Date of coverage under this Policy; 3) expenses for a Pregnancy existing on the Effective Date of coverage under this Policy.

**Reasonable and Customary** means the maximum amount that the Company determines is Reasonable and Customary for Covered Expenses the Insured Person receives, up to but not to exceed charges actually billed. The Company's determination considers: 1) amounts charged by other Service Providers for the same or similar service in the locality were received, considering the nature and severity of the bodily Injury or Illness in connection with which such services and supplies are received; 2) any usual medical circumstances requiring additional time, skill or experience; and 3) other factors the Company determines are relevant, including but not limited to, a resource based relative value scale.

**Relative** means spouse, parent, sibling, Child, grandparent, grandchild, step-parent, step-child, step-sibling, in-laws (parent, son, daughter, brother and sister), aunt, uncle, niece, nephew, legal guardian, ward, or cousin of the Insured Person.