

# COUNCIL FOR EDUCATIONAL TRAVEL, USA

## International Medical & Accident Insurance

### Summer Work/Travel Program

Provided by:

Capistrano Insurance Services, Inc. & AIG (American International Group, Inc.)



#### COVERAGE PROVIDED THROUGH THE INTERNATIONAL ACCIDENT & TRAVEL SICKNESS PROGRAM

#### SUMMER WORK/TRAVEL PROGRAM SUMMARY OF INSURANCE

International Accident & Sickness Medical Coverage is available 24 hours a day when you travel outside your country of residence or country of permanent assignment. The following benefits are available.

##### ACCIDENT & SICKNESS MEDICAL EXPENSE

Provides coverage for reimbursement of covered medical expenses for in-hospital and out-of-hospital treatment.

##### ACCIDENT DEATH & DISMEMBERMENT

Provides coverage of death and dismemberment, including loss of sight or hearing, as the result of a covered accident.

##### EMERGENCY MEDICAL EVACUATION

Provides Coverage for transportation to the nearest medical facility qualified to treat the covered emergency

##### REPATRIATION

Provides coverage for returning the Insured's remains to family members in the event of death.

PLEASE REFER TO THE FOLLOWING  
DESCRIPTION OF BENEFITS AND  
PLAN OPERATIONS FOR FURTHER DETAILS

Benefits	In Network	Out of Network
<b>Accident Death &amp; Dismemberment</b>		
Maximum Amount:	\$5,000	\$5,000
<b>Accident &amp; Sickness Medical Expenses</b>		70% of usual and customary charges up to a maximum of \$250,000
Maximum Amount:	\$250,000	
<b>Deductible, per occurrence:</b>	\$100	\$100
<b>Emergency Room Deductible</b> <i>(If not Admitted or non emergency related visit)</i>	\$250	\$250
<b>Emergency Medical Evacuation:</b>		
Maximum Amount:	\$150,000	\$150,000
<b>Repatriation of Remains:</b>		
Maximum Amount:	\$7,500	\$7,500
<b>Worldwide Assistance Service:</b>	Yes	Yes
<b>Aggregate Limits:</b>	\$500,000	\$500,000

#### YOU ARE REQUIRED TO CONTACT THE AIG MEDICAL HOTLINE:

- ◆ As soon as non-emergency hospitalization is recommended.
- ◆ Within 48 hours of the first working day, following an emergency admission.
- ◆ When your physician recommends any surgery (including outpatient).

**AIG Medical Hotline: (877) 832-6019**



When you need medical attention, contact **Coalition America, Inc.** for a list of Participating Providers at: **(800) 878-7896** or visit our website at **www.coalitionamerica.com**; PIN # 3014.

Coalition America, Inc., administers the networks listed below on behalf of AIG and their plan participants:

**Devon Health Services:** DE, NJ, PA  
**First Choice Health Network:** AK, WA  
**PPO Next. PHN/Healthstar:** AR,AZ,CA  
 CO, FL, IN, KY, NC,NY,CT,DC,IL,IA,IN,  
 KS,KY,MA,MD,ME,ND,NH,SC,VA, OK,  
 RI,SD  
**Galaxy Health Network:** TX, UT

**Health Payors Organization:**  
 NM, OH, WY  
**HMN/RAN/AMN:** NV, NM  
**Interwest:** MT  
**IPN:** ID  
**NovaNet:** AL, GA  
**Providence Preferred:** OR

## What should you do if you have a claim?

### Steps to see an In-Network doctor or Hospital:

**Step 1:** Call **Coalition America** toll free from the United States or Canada at **1-800-878-7896**. (Call collect from anywhere else in the world by contacting an international AT&T operator and request to be connected with **AIG Assist** in Houston, Texas at 01-713-267-2525.) An operator will answer the phone and ask you for your City, State and Zip Code. The operator will then give you a list of doctors or hospitals nearest to you. Please have a pen and paper ready to write the names, phone numbers and addresses of doctors in your area.

You may also access the Internet to find a doctor or hospital at:

<http://www.coalitionamerica.com/SrhPpo/index.htm>

After you accept the disclaimer, enter 3014 as the Client Identifier. You may then select your State and enter the city or zip code to begin your search. Please note that the default search for Type of Provider is for Hospitals. If your purpose to see a doctor is not an emergency, change the Type of Provider to Facilities & Physicians to save money on your deductible.

**Step 2:** Once you find a provider in your area call the phone number of the doctor and schedule an appointment.

**Step 3:** Please be sure to have your Medical ID card available to give to the doctor's office so they may verify coverage with AIG.

**Important:** Remember to contact the **AIG Medical Hotline** at 1-877-832-6019 (toll free) as soon as non-emergency hospitalization is recommended, within 48 hours of the first working day following an emergency admission or when your physician recommends any surgery (including outpatient).

### Steps to see an Out-of-Network doctor or Hospital:

If you are unable to locate an In-network doctor and would like to see an out of network doctor of your choice please follow the instructions below:

**Step 1:** Locate a doctor of your choice and bring the following to your Doctor's office: Your insurance card  
Accident & Sickness Claim Form (GLB\_ASM)

**Note:** If you are unable to locate an In-Network doctor within 25 miles of your City or Zip code you will not be subject to any Out of Network penalties. AIG will pay the claim as if it were an In-Network doctor's visit.

Claim forms are available on the CETUSA website home page: [www.cetusa.org](http://www.cetusa.org). If you do not have access to a computer and you need a copy of the claim form, please call 1-800-551-0824. If you do not have a copy of your insurance card, please contact your plan administrator: Capistrano Insurance Services, Inc. 949-248-4990 Attn: James Henson.

**Important:** If the doctor or hospital calls the AIG Medical Hotline at 1-877-832-6019 AIG will confirm coverage in accordance with the insurance terms and conditions so that the costs will be charged directly to AIG.

Some doctors and hospitals insist on the patient paying the invoice there and then. If this is the case for you please follow the instructions below:

Fill out **Section A** (page 1) of the Accident & Sickness Claim Form (GLB\_ASM) included in this kit. This section is mandatory, and must be filled out in its entirety.

#### This information allows us to:

- Establish the **Date of Loss** which is the date of injury or date your symptoms first occurred. *A claim record cannot be established without a Date of Loss.*
- Validate your coverage
- Collect necessary information about your injury/sickness
- Obtain your current/future address

- Collect details regarding pre-existing medical treatment and treating physicians

Please read the "Assignment of Benefits" section of the claim form and check the appropriate box. This section lets you authorize payment of policy benefits directly to a medical provider. Your signature is needed at the bottom of the form.

Mail the original copy of Section A from the completed Accident & Sickness Claim Form to:  
AIG Claim Services - Accident and Health  
Claims Department  
P.O. Box 1570, Wilmington, DE 19850-5701

*Keep a copy of the completed Accident & Sickness Claim Form for your records.*

Instruct your healthcare provider to submit **ONE** of the following documents to our claims office:

- **An itemized bill** (Name of Claimant, showing dates of service, description and charge of each service and nature of injury/diagnosis) for services rendered. Our claim process **requires the procedure/diagnosis code** be provided by your healthcare provider. A second bill or past due notice does not typically contain this information and may not be substituted

Or, - **Itemized insurance billing forms\*** such as \* CMS/HCFA 1500 form for physicians; UB92 form for facilities)

Your healthcare provider should forward one of the above documents to:

AIG Claim Services - Accident and Health  
Claims Department  
P.O. Box 15701, Wilmington, DE 19850-5701

## EXCLUSIONS

No benefits shall be payable for medical expenses provided by this coverage with respect to expenses incurred:

1. Pre-existing Conditions, defined as any injury or illness which was contracted or which manifested itself, or for which treatment or medication was prescribed prior to the effective date of the insurance;
2. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician;
3. For suicide or any attempt threat while sane or self-destruction of any attempt threat while insane;
4. Declared or undeclared war or any act thereof;
5. For injury sustained while participating in professional athletics;
6. For sickness resulting from pregnancy, childbirth or miscarriage;
7. For miscarriage resulting from accident;
8. For routine physical 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 disability established by the prior call or attendance of a physician;
9. For cosmetic or plastic surgery, except as the result of an accident;
10. For elective surgery which can be postponed until the insured returns to his/her country of residence;
11. For any mental and nervous disorders or rest cures;
12. For dental care, except as the result of injury to natural teeth caused by accident;
13. For 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;
14. In connection with alcoholism and drug addiction, or use of any drug or narcotic agent;
15. For congenital anomalies and conditions arising out of or resulting therefrom;
16. For expenses which are non-medical in nature;
17. For the ordinary cost of a one-way airplane ticket used in the transportation back to the insured's country where an air ambulance benefit is provided;
18. For expenses as a result of or in connection with intentionally self-inflicted injury;
19. For expenses as a result of or in connection with the commission of a felony offense;
20. For specific named hazards; motorcycle driving, scuba diving, skiing out of bounds on unimproved slopes, mountain climbing, sky diving, professional or amateur racing and piloting an aircraft;
21. 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.

#### Accidental Death and Dismemberment Exclusions

This insurance does not cover any loss, fatal or non-fatal, caused by or resulting from:

1. suicide or any attempt threat by the Insured Person while sane or self destruction or any attempt there at by the Insured Person while insane;
2. disease of any kind;
3. bacterial infections except pyogenic infection which shall occur through accidental cut or wound;
4. hernia of any kind;
5. injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in Part B of Section II, Definition of Injury and Scope of Coverage;
6. declared or undeclared war of any act thereof;
7. service in the military, naval or air service of any country;
8. the Insured Person being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.

#### NOTICE TO PROVIDER:

#### TO REPORT CLAIMS OR VERIFY ELIGIBILITY CONTACT:

American International Companies  
Domestic Accident & Health Claims  
P.O. Box 15701, Wilmington, DE 19850-5701  
(800) 551-0824 or (302) 661-4176  
8:30 AM - 5:00 PM Eastern Time, Monday - Friday

#### MEDICAL INSURANCE ID CARD

Carry your ID Card at all times.

Always present it to your medical service provider.

INSURED PERSON

NAME OF ACCOUNT (CETUSA-WT)  
Council for Educational Travel-USA

POLICY NUMBER  
GLB 0009114037

Pre-Certification will not be granted.  
Possession of this card does not guarantee health care benefits or coverage.

**Insurance Company of the State of Pennsylvania**  
 AIG Claim Services  
 A&H Claims Department  
 P. O. Box 15701  
 Wilmington, DE 19850-5701  
 800-551-0824/302-661-4176

**INSTRUCTIONS:**

- 1.) Please complete Section A in full if *initial* submission. Complete first 2 lines, sign and date if *subsequent* submission.
- 2.) Please have Attending Physician attach fully itemized bill(s) including: Patient's Name, Date of Service, Place of Service, Diagnosis, Procedure Code and Description of Services.

**BLANKET ACCIDENT & SICKNESS CLAIM FORM (ASM\_)**

**Section - A**

<b>Name of</b> (as appears on policy) Council for Educational Travel - USA (CETUSA-WT)		<b>Sponsoring Organization</b> (if any)	
<b>Address of</b> (Including city & state)		<b>Policy Number</b> GLB 0009114037	<b>Certificate Number</b>
<b>Claimant's Name</b>		<b>Claimant's Social Security #</b>	<b>Parent's Names</b> (if claimant is a minor)
<b>Claimant's Address</b>		<b>City</b>	<b>State</b> <b>ZIP</b>
<b>Date Claimant Arrived at</b>		<b>Date Claimant Left/Schedule to Leave</b>	<b>Phone Number</b>

**IF AN ACCIDENT CLAIM, COMPLETE THIS SECTION**

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_  AM  PM

<b>Type of Injury:</b> <input type="checkbox"/> Bruise/contusion/abrasion <input type="checkbox"/> Burn <input type="checkbox"/> Fracture <input type="checkbox"/> Dislocation <input type="checkbox"/> Laceration <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Other: _____	<b>Part of Body Injured:</b> <input type="checkbox"/> Ankle <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Face <input type="checkbox"/> Foot (incl. toes) <input type="checkbox"/> Hand (incl. fingers) <input type="checkbox"/> Head <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Shoulder <input type="checkbox"/> Tooth <input type="checkbox"/> Wrist <input type="checkbox"/> Other: _____	<b>Activity at time of Injury</b> <input type="checkbox"/> Dining Hall Activity <input type="checkbox"/> Horseback Related <input type="checkbox"/> Playground Related <input type="checkbox"/> Running <input type="checkbox"/> Swimming <input type="checkbox"/> Walking <input type="checkbox"/> Other Non-Sports _____ <input type="checkbox"/> Sports-related: <input type="checkbox"/> Baseball <input type="checkbox"/> Basketball <input type="checkbox"/> Football <input type="checkbox"/> Field Hockey <input type="checkbox"/> Softball <input type="checkbox"/> Soccer <input type="checkbox"/> Tennis <input type="checkbox"/> Volleyball <input type="checkbox"/> Other Sports: _____
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Where did accident occur? \_\_\_\_\_  On premises  Off premises

Was Claimant involved in a sponsored activity at the time of claim?  YES  NO

Was Claimant working at the time of claim?  YES  NO

**IF A SICKNESS CLAIM, COMPLETE THIS SECTION**

Date of Sickness: \_\_\_\_\_ Hour: \_\_\_\_\_  AM  PM

Describe sickness or condition: \_\_\_\_\_

**FOR ALL CLAIMS, COMPLETE THIS SECTION**

Does the Claimant have other insurance?  YES  NO

If yes, name of company: \_\_\_\_\_ Subscriber's policy number: \_\_\_\_\_

Address: \_\_\_\_\_

Is this a pre-existing condition?  YES  NO

**To whom should payment be made?**         CLAIMANT     PARENT     PROVIDER OF SERVICE

**I hereby certify that the above is a covered individual under the policy and that the injury or sickness was sustained in accordance with the policy provisions.**

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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 containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**For claimants not residing in California, New York, or Pennsylvania:** 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 claimants not residing in California, Florida, New York, or Pennsylvania: 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.**

Official's Name (PRINT) \_\_\_\_\_ Official's Name (SIGNATURE) \_\_\_\_\_ DATE \_\_\_\_\_