

WHAT IS NOT COVERED?

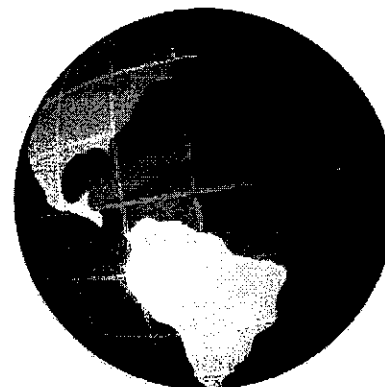
Unless specifically provided for elsewhere under the Participation Certificate, the Participation Certificate does not cover loss caused by or resulting from, nor is any premium charged for, any of the following

1. Expenses incurred in excess of Reasonable Expenses.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health. This exclusion does not apply to services in connection with pediatric preventive care.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury. This exclusion does not apply to hearing aids.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. Elective termination of pregnancy.
7. Expenses incurred as a result of pregnancy that is not covered.
8. For diagnostic investigation or medical treatment for fertility or birth control.
9. Expenses incurred for Injury resulting from the Covered Person's being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. This exclusion does not apply to the Medical Evacuation, to the Repatriation of Remains and to the Bedside Visit Benefit.
10. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
11. Organ or tissue transplant.
12. Participating in an illegal occupation or committing or attempting to commit a felony.
13. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Participation Certificate.
16. Expenses incurred within the Covered Person's Home Country.
17. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
18. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
19. Diagnosis and treatment of acne and sebaceous cyst.
20. Outpatient treatment for specified therapies including, but not limited to, Physiotherapy and acupuncture which does not follow a covered Hospital Confinement or surgery.
21. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
22. Self-inflicted Injuries while sane or insane; suicide, or any attempt thereat while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
23. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion.
24. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
25. Loss arising from a) participating in any professional sport, contest or competition; b) skin/scuba diving, sky diving, hang gliding, or bungee jumping.
26. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
27. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
28. Services or supplies that the Insurer considers to be Experimental or Investigative.

Ramapo College of New Jersey

Study Abroad Program 2009-2010

Blanket Student Accident and Sickness Insurance



Administered by:

HTH Worldwide

One Radnor Corporate Center, Suite 100
Radnor, PA 19087
1.888.243.2358
hthstudents.com

This pamphlet contains a brief summary of the features and benefits for insured participants covered under Policy No. HMT-3123-A-09. This is not a contract of insurance. Coverage is governed by an insurance policy issued to the Trustee of the Highmark Insurance Trust, which Ramapo College New Jersey has agreed to participate in. The coverage is underwritten by HM Life Insurance Company, Pittsburgh, PA, NAIC #0812-93440 under policy form HM207-SI. Complete information on the insurance is contained in the Certificate of Insurance on file with the school. If there is a difference between this program description and the certificate wording, the certificate controls.

WHO IS ELIGIBLE FOR COVERAGE?

All regular, full-time Eligible Participants and their Eligible Dependents of the educational organization or institution who:

1. Are engaged in international educational activities; and
2. Are temporarily located outside his/her Home Country as a non-resident alien; and
3. Have not obtained permanent residency status.

WHEN DOES COVERAGE START?

Coverage for an Eligible Participant and or an Eligible Dependent starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Participation Certificate; OR;
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card, if any;
4. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

WHEN DOES COVERAGE END?

Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Participation Certificate terminates;
2. The Participating Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
5. The date the Eligible Participant leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

WHAT TO DO IN THE EVENT OF AN EMERGENCY

All Eligible Participants are entitled to Global Assistance Services while traveling outside of the United States. In the event of an emergency, they should go immediately to the nearest physician or hospital without delay and then contact HTH Worldwide. HTH Worldwide will then take the appropriate action to assist and monitor the medical care until the situation is resolved. To contact HTH Worldwide in the event of an emergency, call 1.800.257.4823 or collect to +1.610.254.8771.

COORDINATION OF BENEFITS

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

hthstudents.com

Once Eligible Participants receive their Medical Insurance ID card from HTH Worldwide, they should visit hthstudents.com, and using the certificate number on the front of the card, sign in to the site for comprehensive information and services relating to this plan. Participants can track claims, search for a doctor, view plan information, download claim forms and read health and security information.

PRE-EXISTING CONDITION

The Insurer does pay benefits for loss due to a Pre-Existing Condition.

CLAIMS SUBMISSION

Claims are to be submitted to HTH Worldwide, Attn: International Claims, One Radnor Corporate Center, Suite 100, Radnor PA 19087, USA. See the hthstudents.com website for claim forms and instructions on how to file.

WHAT IS COVERED BY THE PLAN?**Schedule of Benefits – Table 1**

	Limits – Covered Person
MEDICAL EXPENSES	
Lifetime Maximum Benefit	\$1,000,000
Plan Year Maximum Benefits	\$250,000
Maximum Benefit per Injury or Sicknesses	\$250,000
Deductible	\$0 per Injury or Sickness
ACCIDENTAL, DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$15,000 for Participant; up to \$5,000 for Spouse; up to \$1,000 for Dependent
REPATRIATION OF REMAINS	Maximum Benefit up to \$25,000
MEDICAL EVACUATION	Maximum Lifetime Benefit up to \$100,000
BEDSIDE VISIT	Up to a maximum benefit of \$5,000 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person

Schedule of Benefits – Table 2 – Medical Expenses

	Indemnity Plan Limits
Physician Office Visits, Inpatient Hospital Services, Hospital and Physician Outpatient Services	100% of Reasonable Expenses.

Schedule of Benefits – Medical Expense Benefits

Benefits listed below are subject to Lifetime Maximums, Annual Maximums, Maximums per Injury and Sickness, Co-Insurance, Deductibles, Out-of-Pocket Maximums; and Table 2 Plan Type Limits

MEDICAL EXPENSE	Limits – Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses. Conception must have occurred while the Covered Person was insured under the Participation Certificate.
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$5,000 Maximum per lifetime for a maximum period of 30 days per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$2,500 Maximum per lifetime
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to \$10,000 Maximum combined total for Inpatient and Outpatient care, up to 30 days immediately following the attending Physician's release for rehabilitation following a covered Hospital confinement or surgery per Plan Year.
Therapeutic termination of pregnancy	Reasonable Expenses up to \$500 Maximum per Plan Year
Routine nursery care of a newborn child of a covered pregnancy	Reasonable Expenses up to \$500 Maximum per Plan Year
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$2,500 per Plan Year maximum
Outpatient prescription drugs including oral contraceptives and devices	100% of actual charge

Medical Reimbursement Form – Claims incurred outside the United States

HTH Worldwide

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form, signing the back of the form and attaching all required documentation will help us to process your claim quickly and accurately.

SEE REVERSE SIDE FOR REQUIRED AUTHORIZATION SIGNATURE AND INSTRUCTIONS

PATIENT INFORMATION				INSURED INFORMATION (on ID Card)	
NAME: Family Name		Given Name		Certificate Number:	Group Name:
Birth Date MM DD YY		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Insured member <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter		
Does The Patient Have Other Health Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reimbursement Mailing Address:			
Name of Other Health Insurance Company:		Contact Phone Number:		Email Address:	
Policy Number					

TO BE COMPLETED BY THE INSURED

Please Describe your Accident or Sickness in the space provided below:

Was this medical expense the result of a **motor vehicle accident**? Yes No

If YES, are you aware of any **pending legal action** relating to this accident? Yes No

Was this condition or injury the result of or caused by the patient's **participation in a sport**? Yes No

Was this medical expense the result of a **work related illness/injury**? Yes No

Have you been **treated for the same condition** within the last 24 months? Yes No

If yes, indicate date treatment began and date you were last treated: Began Treatment on: _____ Last Treatment Date: _____

MEDICAL INFORMATION

Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan. Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

Date of Service (Mo/Day/Yr)	Provider of Service (Name of Doctor, Lab, Ambulance Company, etc.)	Service Rendered (Office Visit, X-ray, Prescription, etc.)	Illness or Diagnosis	Total (Please Indicate Currency)
GRAND TOTAL				

PAYMENT INFORMATION

Payment Method: **Check** (payable in US\$ and mailed to the address indicated above) **Wire Transfer** (bank information below) **Pay the Provider Directly**

Note: In order for HTH Worldwide to wire funds for reimbursement of claims, complete, accurate and legible information must be provided below. Funds will be wired in the currency in which it is billed, or another currency, if available*. If the billed currency is not available for wire transfer, funds will be wired in US Dollars.

Bank Name:	Bank ABA Number / SWIFT Code:
Bank Address:	
Account Holder Name:	Bank Account Number:
Currency Type:	

*Current available currencies are (subject to change): Australian Dollar, Canadian Dollar, Swiss Franc, Czech Koruna, Danish Kroner, Euro, Fiji Dollar, British Pound, Hong Kong Dollar, Hungarian Forint, Indian Rupee, Japanese Yen, Kuwaiti Dinar, Mexican Peso, Norwegian Kroner, New Zealand Dollar, Papua New Guinea Kina, Philippine Peso, Polish Zloty, Saudi Arabian Riyal, Swedish Kroner, Singapore Dollar, Slovak Koruna, South African Rand, Taiwan Dollar, Thai Bhat, Venezuelan Bolivar

AUTHORIZATION

Certification and Release of Information: I certify that the information on this Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. If I checked the Pay the Provider box above, I authorize payment directly to those Health Care Providers described below, and/or indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them. This claim will be returned if this claim form is not signed.

Except as otherwise indicated below, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

For your protection, **California** 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 a state prison.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Applicants applying for accident and health insurance in New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Oklahoma, WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In **Kentucky and Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Washington**, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

X _____
Signature of Insured Member Date

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Normally, providers of health care will bill us directly for services to you and your enrolled dependents. This is the preferred procedure.

When your health care provider bills us, you do not need to send us a claim form. If a physician, ambulance company or other provider sends their bill directly to you, we have no way of knowing about your claim until we have received your bill at HTH Worldwide. This Member Claim Form was developed for you to notify us of any covered health services for which we have not already been billed.

Please read the following instructions about how to report health care services.

Bills must be itemized: Canceled checks, cash register receipts and non-itemized "balance due" statements cannot be processed.

Each itemized bill must include: Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.), Name of patient, Date(s) of service, Amount charged for each service, Total Charge, Diagnosis or reason for treatment

In addition, the following information must also be included on bills for the service types listed below:

- **Registered and Licensed Vocational Nursing Services:** Hours and dates of service; Location of service (residence or name of hospital); Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)
- **Ambulance:** Pick-up and delivery points; Number of miles
- **Anesthesia:** Start Time; End Time; Surgical procedure; Surgeon Name and address
- **Prosthetic Devices, Appliances or Durable Medical Equipment:** Doctor's orders or prescriptions; Purchase price
- **Outpatient Prescription Drugs:** Duplicate pharmacy generated receipt (not register tape) - must include Rx Number; Date Filled, Medication Name, Form, Strength and Quantity (NOTE: All Prescription Drug charges will be reimbursed to the insured person only)

SEND COMPLETED CLAIM FORM TO:

**HTH Worldwide
One Radnor Corporate Center, Suite 100
Radnor, PA 19087
Fax: 610-293-3529**