

PRE-EXISTING CONDITION

The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first one (1) year of coverage, except as follows: The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the first one (1) year of coverage, subject to a maximum benefit of \$1,000. This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

WHAT IS NOT COVERED?

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

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
2. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
3. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses, contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
4. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
5. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
6. Expenses incurred in excess of Reasonable Expenses.
7. 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, the Repatriation of Remains and to the Bedside Visit Benefit.
8. 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.
9. Organ or tissue transplant.
10. Participating in an illegal occupation or committing or attempting to commit a felony.
11. 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.)
12. 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.
13. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
14. 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.
15. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
16. Diagnosis and treatment of acne and sebaceous cyst.
17. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
18. 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.
19. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion; or acts of terrorism.
20. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
21. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting or bungee jumping.
22. 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.
23. 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.
24. Expenses incurred as a result of pregnancy that is not covered.

St. Andrews Presbyterian College

2009 – 2010

Blanket Accident and Sickness Insurance



Administered by:

HTH Worldwide

One Radnor Corporate Center, Suite 100

Radnor, PA 19087

1.888.350.2002

hthstudents.com

This pamphlet contains a brief summary of the features and benefits for insured participants covered under Policy No. U-1211-09a, underwritten by an A- rated life and health insurance company. This policy complies with state mandated benefits for North Carolina and therefore, Participants may be entitled to additional benefits. Please see the Certificate of Insurance on file with the school for more information. Any provisions of this certificate that may be in conflict with the laws of the state where the purchaser is located will be administered to conform with the requirements of that state's laws, including mandated benefits. 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 of the educational organization or institution and their Eligible Dependants 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 their Eligible Dependants starts at 12:00:01 a.m. on the latest of the following: 1. The effective date of the Policy; 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. 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 and their Eligible Dependand will automatically terminate on the earliest of the following dates:

1. The date the Policy 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 and their Eligible Dependants 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.

EXCESS COVERAGE

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.

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Once Eligible Participants and their Eligible Dependants 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.

CLAIMS SUBMISSION

Claims are to be submitted to HTH Worldwide, PO Box 968, Horsham, PA 19044, 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
Lifetime Maximum Benefit	\$800,000
Policy Year Maximum Benefits	\$400,000
Maximum Benefit per Injury or Sicknesses	\$100,000
Policy Year Out-of-Pocket Limit *	\$2,500 Out-of-Pocket Limit per Policy Year
Accidental Death & Dismemberment	Maximum Benefit: Principal Sum up to \$10,000 for Participant, \$5,000 for Spouse, and \$1,000 for Child(em)
Repatriation of Remains	Maximum Benefit up to \$15,000
Medical Evacuation	Maximum Lifetime Benefit up to \$100,000
Bedside Visit	Up to a maximum benefit of \$1,000

*After the Covered Person reaches a \$2,500 Out-of-Pocket Limit per Policy Year, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Copayments and amounts above the maximums do not apply toward the Out-of-Pocket Limit.

Schedule of Benefits – Table 2 – Medical Expenses

	PPO Plan - In PPO Limits	PPO Plan - Outside PPO Limits
Physician Office Visits*	100% of Reasonable Expenses after \$50 Copayment per visit	75% of Reasonable Expenses
Inpatient Hospital Services	100% of Reasonable Expenses after \$100 Copayment per visit	75% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses after \$100 Copayment per visit	75% of Reasonable Expenses

Schedule of Benefits – Medical Expense Benefits

Benefits listed below are subject to Table 1 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
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$10,000 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 \$1,000 Maximum per lifetime
Outpatient back and spine treatment (including modalities)	Reasonable Expenses up to \$1,000 Maximum per Policy Year with a \$50 per visit maximum.
Treatment of Specified Therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to \$1,000 Maximum per Policy Year on an Inpatient Basis. Reasonable Expenses up to \$50 Maximum per visit subject to a Maximum of 20 visits on an Outpatient Basis. This Benefit is per Policy Year
Therapeutic or elective termination of pregnancy	Reasonable Expenses up to \$500 In PPO Maximum per Policy Year or up to \$400 Outside PPO Maximum per Policy Year
Routine nursery care of a newborn child of a covered pregnancy	Reasonable Expenses up to \$750 Maximum per Policy Year
Annual cervical cytology screening for women	Reasonable Expenses
Low dose mammography screening	Reasonable Expenses
Medical treatment arising from participation in intercollegiate, interscholastic or club sports.	Reasonable Expenses up to \$10,000 Maximum per Policy Year.
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$500 per Policy Year maximum
Outpatient prescription drugs including oral and Norplant contraceptives	50% of actual charge
Medical treatment received in the Home Country, if NOT covered by Other Plan	100% of Reasonable Expenses up to \$1,000 lifetime maximum