**UNIVERSITY HEALTH PLANS, INC.**

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**WRIGHT STATE UNIVERSITY**

**2017-2018 INTERNATIONAL TRAVEL INSURANCE PLAN PROPOSAL**

**This insurance plan is to be combined with an International SOS Comprehensive (Insured) Program that is provided through a separate contract.**

**Proposal Date:** April 17, 2017

**Insurance Company:** Nationwide Mutual Insurance Company

**Program Coordinator:** University Health Plans

**Participating Organization:**

Name:Wright State University

3640 Colonel Glenn Hwy.

Dayton, OH 45435

**Eligibility:**

Students, Faculty, Scholars, or other persons of the Participating Organization with a current passport or student visa, who are temporarily residing outside the United States on an academic Study Abroad program.

**Coverage:** Mandatory for all eligible participants of Wright State University International Travel Insurance Programs

**Coverage Types:**

**Coverage 1:** International Medical

**Coverage 4a:** ISOS Case Fees - Medical

**Territory Restrictions:**

* United States\*
* Cuba, Unless a valid travel license is obtained from the United States

\* *The U.S. is defined as the 50 United States and the District of Columbia.*

**Period of Coverage:** Master Agreement Year: May 1, 2017 through April 30, 2018. No Insured person may have a policy period longer than twelve (12) months.

Effective Date of Coverage begins on the latest of the following:

1. The Date the Company receives a completed enrollment form and premium for the Policy Period; or

2. The Effective Date requested on the enrollment form; or

3. The moment the Insured Person departs their Home Country airspace.

Expiration Date of Coverage terminates on the earlier of the following:

1. The moment the Insured Person returns to their Home Country; or

2. The expiration of twelve (12) months from the Effective Date of Coverage; or

3. The date shown on the Certificate issued by the Company; or

4. The end of the period for which premium has been paid; or

5. The Date the Insured Person fails to be considered an Eligible Person; or

6. The maximum benefit amount has been paid.

**COVERAGE #1: INTERNATIONAL MEDICAL**

**SCHEDULE OF BENEFITS:**

|  |  |
| --- | --- |
| All Coverages and Benefits are in U.S. Dollar Amounts | |
| Medical Maximums  Accident Medical; Sickness Medical | Per Injury or Illness:  $500,000 per Primary Insured |
| Deductible per Injury or Illness | $0 |
| Coinsurance | This plan pays 100% of eligible expenses to the Medical Maximum |
| Benefit Period | Period of Coverage |
| Maternity | Up to Sickness Medical Maximum |
| Alcohol and Drug Abuse per Lifetime | Inpatient: Payable at 100% up to Medical Maximum, up to a maximum of 40 days  Outpatient: Payable at 100% up to Medical Maximum, up to a maximum of 30 visits |
| Injuries from a Motor Vehicle Accident | Up to Accident Medical Maximum |
| Dental (Emergency) | Up to $2,000 per Period of Coverage |
| Dental (Palliative) | Up to a maximum of $500 per Period of Coverage |
| Loss of Baggage | Up to $250 per Period of Coverage |
| Trip Interruption – Return Ticket | Up to $2,000 |
| Accidental Death & Dismemberment (“AD&D”)  Aggregate Limit of Indemnity per Accident | Principal Sum:  $10,000 per Primary Insured; $5,000 Spouse/Dependent Child  Five times the principal sum to a maximum aggregate of $50,000 |

**DESCRIPTION OF BENEFITS**

**Medical Expenses:**

This Plan shall pay Reasonable and Customary charges for Covered Expenses up to the Medical Maximum, incurred by you, due to an accidental Injury or Illness which occurred during the Period of Coverage outside your Home Country. The initial Treatment of an Injury or Illness must occur within thirty (30) days of the date of Injury or onset of Illness.

Only such expenses which are specifically enumerated in the following list of charges are incurred within the Benefit Period, and which are not excluded, shall be considered Covered Expenses:

1) Charges made by a Hospital for semi-private 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.

2) Charges made for Intensive Care or Coronary Care charges and nursing services.

3) Charges made for diagnosis, Treatment and Surgery by a Physician.

4) Charges made for an operating room.

5) 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.

6) Charges made for the cost and administration of anesthetics.

7) Charges for Medication, X-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, medical ventilator, and medical Treatment.

8) Charges for physiotherapy as the result of Covered Accident, to a maximum of $2,500, if recommended by a Physician for the Treatment of a specific Disablement following hospitalization and administered by a licensed physiotherapist.

9) Charges for physiotherapy as the result of Covered Sickness, if recommended by a Physician for the Treatment of a specific Disablement following hospitalization and administered by a licensed physiotherapist.

10) Dressings, drugs, and Medicines that can only be obtained upon a written prescription of a Physician or Surgeon.

11) 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, within the metropolitan area in which you are located at that time the service is used. If you are in a rural area, then licensed air ambulance transportation to the nearest metropolitan area shall be considered a Covered Expense. Covered Expenses shall not exceed the Medical Maximum stated in the Schedule of Benefits.

**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 you Period of Coverage; or
  2. The maximum benefit has been paid; or
  3. Your release from the hospital or Physician care.

**Pre-notification:**

For each scheduled hospital admission or emergency hospital confinement, you or someone on your behalf must contact the assistance company for pre-notification as soon as possible, but no later than 48 hours prior to the admission to the hospital, or of the hospital confinement. For Emergency Hospital Confinement, you or someone on your behalf must notify the assistance company as soon as possible, but no later than 48 hours after the date of admission. Pre-notification does not guarantee or confirm benefits or the payment of said benefits.

**Maternity:**

When covered maternity expenses are incurred by Your or Your eligible dependents, the Company will pay Reasonable Charges for medical expenses. 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.

You or Your representative must notify the Company of a Pregnancy within the first trimester.

As stated in the Schedule of Benefits, benefits will be payable for covered expenses You incur before, during, and after delivery of a child, including physician, hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for You and Your newborn child in a hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for perinatal care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Your attending physician determines further Inpatient postpartum care is not necessary for You or Your newborn child provided the following are met:

1. In the opinion of Your attending physician, the newborn child meets the criteria for medical stability in the guidelines for perinatal care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
2. The antepartum, intrapartum, postpartum course of the mother and infant;
3. The gestational stage, birth weight, and clinical condition of the infant;
4. The demonstrated ability of the mother to care for the infant after discharge; and
5. The availability of post discharge follow up to verify the condition of the infant after discharge; and
6. One (1) at-home post delivery care visit is provided to You at Your residence by a physician or nurse performed no later than forty-eight (48) hours following discharge for You and Your newborn child from the hospital. Coverage for this visit includes, but is not limited to:
7. Parent education;
8. Assistance and training in breast or bottle feeding; and
9. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At Your discretion, this visit may occur at the physician’s office.)

**Alcohol and Drug Abuse:**

Benefits will be paid for Treatment or medication for Alcohol and Drug Abuse; provided said Treatment or medication is not excluded and covered under this policy, it shall be considered a Covered Expense. Benefits shall be payable up to the maximum, as stated in the Schedule of Benefits.

**Dental – Emergency:**

Benefits are paid for Reasonable and Customary expenses up to the maximum as stated in the Schedule of Benefits, for the emergency repair or replacement to sound, natural teeth damaged as the result of a Covered Accident.

**Dental – Palliative (Emergency Relief of Pain):**

This plan shall pay up to the maximum as stated in the Schedule of Benefits, for emergency treatment for the relief of pain to natural teeth.

**Loss of Baggage:**

This Plan will reimburse You for loss, theft or damage to Your baggage or personal effects, checked with a Common Carrier provided You have taken all reasonable measures to protect, save and/or recover Your property at all times. This Plan is secondary to any coverage provided by a Common Carrier and all other valid and collective insurance. This Plan will pay the lesser of: 1) the actual cash value (cost less proper deduction for depreciation at the time of loss, theft or damage); 2) the cost to repair or replace the article with material of a like kind and quality; or, 3) $100 per article, up to the maximum as stated in the Schedule of Benefits. Certain exclusions do apply.

**Trip Interruption – Return Ticket:**

If your trip is interrupted due to one of the following reasons:

1. Death of a Family Member

Benefits will be paid up to the maximum as stated in the Schedule of Benefits for the cost of economy travel less the value of applied credit from an unused return travel ticket to return you home to your area of principal residence

**Accidental Death & Dismemberment:**

Benefits shall be paid to you if you sustain an accidental Injury. The Injury must occur during the Period of Coverage and death or dismemberment as a result of that accident must occur within 365 days from the date of Accident. Benefits payable for any such loss shall be in accordance with the following table: If you incur more than one Loss stated in the following Table as the result of one Accident, only the largest amount shall be payable.

|  |  |
| --- | --- |
| **Description of Loss** | **Percent of Principal Sum** |
| Life | 100% |
| Both Hands or Both Feet or Sight of Both Eyes | 100% |
| One Hand and One Foot | 100% |
| Either Hand or Foot and Sight of One Eye | 100% |
| Either Hand or Foot | 50% |
| Sight of One Eye | 50% |
| Quadriplegia | 100% |
| Paraplegia (total paralysis of both lower limbs) | 75% |
| Hemiplegia (total paralysis of upper and lower limbs of one side of the body) | 50% |
| Uniplegia (total paralysis of one limb) | 20% |

**PLAN DEFINITIONS**

**Benefit Period** shall mean the allowable time period you have from the date of Injury or onset of Illness to receive Treatment for a Covered Injury or Illness.

**Coinsurance** shall mean the percentage amount of Covered Expenses which is your responsibility to pay.

**Deductible** shall mean the amount of Covered Expenses which is your responsibility to pay before benefits under the Plan are payable.

**Home Country** shall mean the country where you have your true, fixed and permanent home and principal establishment.

**Illness** shall mean Sickness or disease of any kind contracted and commencing after the Effective Date of this Plan.

**Injury** shall mean accidental bodily Injury or injuries caused by an Accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other causes. Any loss due to Injury must begin after the Effective Date of this Plan.

**Inpatient** shall mean if you are confined in an institution and are charged for room and board.

**Outpatient** shall mean if you receive care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician’s office, for an Illness or Injury, but who is confined and is not charged for room and board.

**Reasonable and Customary** shall mean the maximum amount that the Plan determines is Reasonable and Customary for Covered Expenses you receive, up to, but not to exceed, charges actually billed. The determination considers: 1) amounts charged by other Service Providers for the same or similar service in the locality where 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 included but not limited to, a resource based relative value scale.

**Treatment** shall mean a specific in-office or Hospital physical examination of, or care rendered to you; consultation; diagnostic procedures and services; Surgery; medical services and supplies, including Medication prescribed or provided by a Service Provider.

**You, Your** or **Insured** shall mean Insured Person.

**EXCLUSIONS AND LIMITATIONS**

**No Benefit shall be payable for Accident Medical, Sickness Medical, Maternity, Alcohol and Drug Abuse, Dental (Emergency), and Dental (Palliative) as the result of:**

* 1. Injury or Illness which is not presented to the Company for payment within three (3) months of receiving Treatment;
  2. Charges for Treatment which is not Medically Necessary;
  3. Charges provided at no cost to you;
  4. Charges for Treatment which exceeds Reasonable and Customary charges;
  5. Charges incurred for Surgery or Treatments which are Experimental/Investigational, or for research purposes;
  6. 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;
  7. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with:
  8. war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war
  9. mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power
  10. acting on behalf of, or in connection with, any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence
  11. martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the “Occurrences”)

Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, arising in connection with, any of the said Occurrences shall be deemed to be consequences for which the Plan shall not be liable for, except to the extent that you prove that such consequence happened independently of the existence of such abnormal conditions;

* 1. Injury sustained while participating in professional athletics;
  2. 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;
  3. Treatment of the Temporomandibular joint;
  4. Vocational, speech, recreational or music therapy;
  5. Services or supplies performed or provided by a Relative of yours, or anyone who lives with you;
  6. Cosmetic or plastic Surgery, except as the result of a covered Accident; for the purposes of this Plan, Treatment of a deviated nasal septum shall be considered a cosmetic condition;
  7. Elective Surgery which can be postponed until you return to your Home Country, where the objective of the trip is to seek medical advice, Treatment or Surgery;
  8. Treatment and the provision of false teeth or dentures, normal ear tests and the provision of hearing aids;
  9. Eye refractions or eye examinations for the purpose of prescribing corrective lenses for eyeglasses, or for the fitting thereof, unless caused by Accidental bodily Injury incurred while covered hereunder;
  10. Expenses which are non-medical in nature;
  11. Expenses as a result of, or in connection with, the commission of a felony offense;
  12. Injury sustained while taking part in mountaineering where ropes or guides are normally used; hang gliding; parachuting; racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle riding; scuba diving involving underwater breathing apparatus, unless certified; and spelunking. ***Note that this exclusion does not apply if the activity is a University Sponsored program.***
  13. 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 any cost to you;
  14. Dental care, except as the result of Injury to natural teeth caused by Accident, unless otherwise covered under this Plan;
  15. Routine Dental Treatment;
  16. 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;
  17. Treatment for human organ tissue transplants and their related Treatment;
  18. Expenses incurred while in your Home Country;
  19. Expenses incurred during a Hospital emergency visit which is not of an emergency nature;
  20. Injury sustained as the result of the Insured Person operating a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place;
  21. Covered Expenses incurred for which the Trip to the Host Country was undertaken to seek medical Treatment for a condition;
  22. Covered Expenses incurred during a Trip after your Physician has limited or restricted travel;
  23. Sex change operations, or for Treatment of sexual dysfunction or sexual inadequacy;
  24. Weight reduction programs or the surgical Treatment of obesity.

**No Benefit shall be payable for Accidental Death and Dismemberment as the result of:**

1. Suicide, or attempt thereof, while sane, or self destruction, or any attempt thereof, while insane;
2. Bacterial infections, except pyogenic infection, which shall occur through an accidental cut or wound;
3. Hernia of any kind;
4. Injury sustained while you are riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft;
5. Injury sustained while you are riding as a passenger in any aircraft (a) not having a current and valid Airworthy Certificate; and, (b) not piloted by a person who holds a valid and current certificate of competency for piloting such aircraft;
6. Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with:
7. war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war
8. mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power
9. acting on behalf of, or in connection with, any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by terrorism or violence
10. martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege (hereinafter for the purposes of this Exclusion called the “Occurrences”)

Any consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed to be consequences for which the Plan shall not be liable, except to the extent that you can prove that such consequence happened independently of the existence of such abnormal conditions;

1. Service in the military, naval or air service of any country;
2. Flying in any aircraft being used for, or in connection with, acrobatic or stunt flying, racing or endurance tests;
3. Flying in any rocket-propelled aircraft;
4. Flying in any aircraft being used for, or in connection with, crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting or herding, aerial photography, banner towing or any experimental purpose;
5. Flying in any aircraft which is engaged in any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted;

# Sickness of any kind;

1. Injury occasioned or occurring while you are committing or attempting to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;
2. While riding or driving in any kind of competition; ***Note that this exclusion does not apply if the activity is a University Sponsored program.***
3. This Plan does not insure against loss or damage (including death or Injury) and any associated cost or expense resulting directly or indirectly from the discharge, explosion or use of any device, weapon or material employing or involving nuclear fission, nuclear fusion or radioactive force, or chemical, biological, radiological or similar agents, whether in time of peace or war, and regardless of who commits the act, regardless or any other cause or event contributing concurrently or in any other sequence thereto.

**No Benefit will be payable for Baggage Loss and Delay for:**

1. Aircraft, automobiles, automobile equipment, motors, motorcycles, bicycles (except bicycles when checked as baggage with a common carrier,) boats or other conveyances or their accessories;
2. Animals;
3. Artificial teeth or limbs, hearing aids;
4. Sunglasses, contact lenses or eyeglasses;
5. Documents of any kind, including but not limited to documents, bills, currency, deeds, evidences of debt, letters of credit, stamps, credit cards, money, notes, securities, transportation or other tickets;
6. Household furniture or furnishings.

**Insurance Quote - RENEWAL**

**Insurance Company:** Nationwide Mutual Insurance Company

**Program Description:** Wright State University

**Date:** April 17, 2017

**RATES FOR THE 2017/18 POLICY YEAR:**

|  |  |
| --- | --- |
| **Coverage 1 – Medical** | **Daily Rates:** |
| **Student Rate:** | 1.05 |
|  |  |
| **Coverage 4a – ISOS Medical Case Fees** | **Daily Rates:** |
| **Student Rate:** | 0.10 |

|  |  |
| --- | --- |
| **Total Rates** | **Daily Rates:** |
| **Student Rate:** | 1.15 |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Wright State University

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**