EIIA

2026-2027

# SPECIALTY ICS INTERNATIONAL STUDENT PLAN

**Policy Number: CC011110**

Capital University

*Keep this summary of coverage for future reference.*

## COVERAGE

This brochure is a brief description of the benefits provided through your institution for international students enrolled full-time or part-time for the 2026-20267 academic year. The policy term will cover enrolled students who purchase this coverage from August 1, 2026 through July 31, 2027.

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain U.S. residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover U.S. residents and citizens.

## ELIGIBILITY

Non-United States Citizen traveling outside their Home Country and has his or her true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain U.S. residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover U.S. residents and citizens. This policy is not subject to guaranteed issuance or renewal.

This policy is rated on an annual only basis. Any changes to a daily rate will incur additional administrative fees. Billing is done in a monthly 30-day window regardless of how many days are needed.

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether this policy meets any obligations you may have under PPACA.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31 day period. Once notified, premium must be paid for coverage to continue for the dependent.

## CANCELLATIONS & REFUNDS

You can cancel your policy and receive a full refund if we receive written notification prior to your certificate effective date. After the effective date of your policy, there is a $25 cancellation fee and any whole unused months will be refunded to you. No refunds are possible if claims are filed against the policy or if you are 60 days past your effective date. Once you have practiced or played then no refunds are possible.

## RIGHT OF REIMBURSEMENT / SUBROGATION

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

# DEFINITIONS

The male pronoun includes the female whenever used.
Additional terms may be defined within the provision to which they apply.

**Accident** means an unforeseeable event which:

1) Causes Injury to one or more Plan Participants; and
2) Occurs while coverage is in effect for the Plan Participant.

**Benefit Period** means the period of time from the date of the Accident causing the Injury or Sickness for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

**Coinsurance** means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

**Company** means Crum & Forster SPC on and behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

**Co-Payment** means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

**Contraceptive Devices** include one IUD every two years (including removal), diaphragm, and cervical caps.

**Contraceptive Drugs** include oral contraceptives (combined estrogen and progestin and progestin-only), NuvaRing, Depo Vera and Ortho Evra.

**Deductible** means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Policy. It applies separately to each Plan Participant.

**Elective Treatment and Procedures** means any Medical Treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

**Eligible Expenses** means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury or Sickness.

**Emergency/Emergency Treatment** means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

**Host Country** means any country other than the country where an Plan Participant has his or her true, fixed and permanent home and principal establishment and holds a current and valid passport.

**Hospital** means an institution licensed, accredited or certified by the State that:

1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
4) Has a staff of one or more licensed Physicians available at all times;
5) Provides organized facilities for diagnosis, treatment and surgery, either

a) on its premises; or

b) in facilities available to it, on a pre-arranged basis;

6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and

7) Is not a place for drug addicts, alcoholics or the aged.

**Hospital** also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1) the Joint Commission of Accreditation of Hospitals; or

2) the American Osteopathic Association; or

3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Policy.

**Hospital does not include** a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

**Injury** means bodily harm which results independently of disease or bodily infirmity, from an Accident. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

**Inpatient** means a Plan Participant who is confined in an institution and is charged for room and board.

**Maximum Benefit** means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

**Medically Necessary** means a treatment, drug, device, service, procedure or supply that is:

1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;

2) Prescribed or ordered by a Physician or furnished by a Hospital;

3) Performed in the least costly setting required by the condition;

4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and

Drug Administration;

- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

**Natural Teeth** means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

**Network Provider** means a Physician, Hospital and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

The availability of specific providers is subject to change without notice. You should always confirm that a Network Provider is participating at the time services are required by calling us at 1-800-226-5116 and/or by asking the provider when you make an appointment for services.

**Non-Network Provider** means a Physician, Hospital and other healthcare providers who have not agreed to any pre-arranged fee schedules. A Plan Participant may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Plan Participant's responsibility.

**Occurrence** means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

**Outpatient** means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

**Outpatient Surgical Facility** means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

**Out-of-Pocket Maximum** means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

**Physician** means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

**Physical Therapy** means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

**Policy Period** means the period of time following the Policy's Effective Date, as shown on the Schedule of Benefits.

**Preferred Allowance** means the amount a Network Provider will accept as payment in full for Eligible Expenses.

**Pregnancy** means the physical condition of being pregnant, including Complication of Pregnancy.

**Prescription Drugs** means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

**Rehabilitation Facility** means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or

2) A free standing facility.

**Sickness** means illness or disease which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

**Usual, Reasonable and Customary** means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

***TO BE ELIGIBLE FOR REIMBURSEMENT, A CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS FROM THE DATE OF SERVICE OR DATE OF DEATH.***

## SCHEDULE OF BENEFITS

**Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown:**

### If you are not suffering from an emergency or need immediate treatment, please consider seeking treatment at the Student Health Center. Many services can be rendered at no cost.

| BENEFIT COVERAGE | BENEFIT AMOUNT |
|---|---|
| **Policy Term Maximum for all Medical Expense:** | **$100,000** |
| **Deductible Per Plan Participant Per Policy Term:** | **$100 (The deductible will be waived when treatment is rendered at the Student Health Center.)** |
| **Out-of-Pocket Maximum Per Plan Participant Per Policy Term:** | **Single: $2,500**<br>**Family: $5,000** |
| **Coinsurance:** | **100% of Usual, Reasonable and Customary (URC)** |
| ***After the Deductible has been satisfied, benefits will be paid as listed below.*** | |
| Hospital Room & Board Benefit | Semi-Private Room Rate; URC after a $50 copayment per visit |
| Intensive Care/Cardiac Care Unit Benefit | 100% of URC |
| Hospital Miscellaneous Expense Benefit | 100% of URC |
| Surgeon (In or Outpatient) Benefit | 100% of URC |
| Assistant Surgeon Benefit | 100% of URC |
| Pre-Admission Testing Benefit | 100% of URC |
| Anesthesia Benefit | 100% of URC |
| Day Surgery Miscellaneous Benefit | 100% of URC after a $50 copayment per visit |
| Diagnostic X-Ray and Lab Benefit | 100% of URC |
| Ambulance Benefit | Actual Charges |

| | |
|---|---|
| Physician Visit Benefit (Inpatient) | 100% of URC |
| Physician Visit Benefit (Outpatient) | 100% of URC subject to a $30 copay |
| Consultant Physician Benefit | 100% of URC subject to a $30 copay |
| Radiation/Chemotherapy Benefit | 100% of URC |
| Emergency Room Benefit | 100% of URC subject to a $35 copayment, waived if admitted |
| Wellness Medical Benefit | 100% of URC (plan deductible does not apply) limited to $5,000 per Policy Year |
| Extension of Accident and Sickness Medical Benefits | 100% of URC |
| Maternity and Pre-Natal Care Expense Benefit | Covered as any other sickness |
| Contraceptive Drugs & Devices | Covered as any other sickness |
| Intercollegiate Sports Benefit | 100% of URC, subject to a maximum of $5,000 per injury |
| | |
| **MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT** | |
| In-Patient Expense | Covered as **any** other sickness up to a maximum of $25,000 per policy year. |
| Out-Patient Expense | Covered as any other sickness up to a maximum of $5,000 per policy year. |
| | |
| **ALCOHOL & DRUG ABUSE EXPENSE BENEFIT** | |
| In-Patient Expense | Covered as any other sickness up to a maximum of $25,000 per policy year. |
| Out-Patient Expense | Covered as any other sickness up to a maximum of $5,000 per policy year. |
| | |
| Emergency Dental Expense Benefit (Injury only) | 100% of URC up to $1,000 maximum benefit |
| | |
| Physiotherapy Expense Benefit | |
| In-Patient Expense | 100% of URC |
| Out-Patient Expense | 100% of URC |
| | |
| **PRESCRIPTION DRUG EXPENSE BENEFIT** | **OPTUM RX NETWORK** |
| Co-payment Generic: | $20 per prescription based on a 31-day supply per prescription |
| Co-payment Brand Name Preferred | 25% Coinsurance per prescription based on a 31-day supply per prescription |
| Co-payment Brand Name Non-Preferred | 35% Coinsurance per prescription based on a 31-day supply per prescription |
| | |

***NOTES:***

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-pay amount.
- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

## SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as a Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.
We will provide the benefits described in the Policy to all Plan Participants who suffer a Covered Loss which:

1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
2) Occurs while the person is a Plan Participant under the Policy.

# TERMS OF PAYMENT FOR BENEFITS

### Primary Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services on the SCHEDULE OF BENEFITS, We will pay the first one hundred dollars ($100) of the Eligible Expenses incurred, subject to any applicable Deductible Amount, Co-Payment and Coinsurance Percentage.

Additional Eligible Expenses will be paid only when they are in excess of amounts payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Eligible Expense must be incurred solely for the treatment of a covered Injury or Sickness:

1) While the person is a Plan Participant under the Policy; or
2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

   The first Eligible Expense must be incurred within the time frame stated on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

### DESCRIPTION OF BENEFITS

#### ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an Accident or Injury covered by the Plan Document, the Plan Participant suffers from a Covered Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Plan Participant sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Plan Participant. The Principal Sum is the Maximum Benefit Amount shown in Schedule of Benefit.

**Benefits are payable if such Injury:**

1) Occurs during the course of time the Plan Participant is covered under the Policy;
2) is sustained during such Trip while the Plan Participant is riding as a passenger (but not as a pilot, operator or member of the crew) in or on, boarding or alighting from:
   a) any civilian aircraft having a current and valid Airworthiness Certificate, and piloted by a person who then holds a valid and current certificate of competency of a rating authorizing him to pilot such aircraft**.**

Provided that this Insurance will not apply while such Plan Participant is riding in any civilian or military aircraft other than as expressly described above, unless previously consented to in writing by the Company.

| LOSS OF: | Benefit Limit: |
|---|---|
| Loss of Life | $10,000 |
| Loss of Both Hands | $10,000 |
| Loss of Both Feet | $10,000 |
| Loss of Entire Sight of Both Eyes | $10,000 |
| Loss of One Hand and One Foot | $10,000 |
| Loss of One Hand and Entire Sight of One Eye | $10,000 |
| Loss of One Foot and Entire Sight of One Eye | $10,000 |
| Loss of One Hand | $5,000 |
| Loss of One Foot | $5,000 |
| Loss of Entire Sight of One Eye | $5,000 |

| | |
|---|---|
| Loss of Thumb and Index Finger of the Same Hand | $2,500 |

**Loss of a hand or foot** means complete Severance through or above the wrist or ankle joint.

**Loss of sight** means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

**Loss of a thumb and index finger** means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

**Severance** means the complete separation and dismemberment of the part from the body.

### ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Injury and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Injury and Sickness Medical Expense Benefits are only payable:

1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
3) for Eligible Expenses incurred within 30 days after the date of the Eligible Expense.

## ADDITIONAL BENEFITS

### HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital 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.

### INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care / Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

### HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

### SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

## ASSISTANT SURGEON BENEFIT

If, in connection with such operation, a Plan Participant requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

## ATHLETIC SPORTS BENEFIT

Coverage is provided up to the maximum amount payable as stated in the schedule if the Plan Participant's Injury or Sickness results from an intercollegiate athletic sport listed on the submitted census**.**

## PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 3 days of the testing).

## ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

## DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

## DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x -ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

## AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area.

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

## PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

## PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

## CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Expenses incurred.

## EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Injury or Sickness.

**Emergency Room** means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

## WELLNESS MEDICAL EXPENSE BENEFIT

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. This benefit is not subject to Deductible or Coinsurance. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1) Routine physical examinations
2) Preventive medical attention.

## EXTENTION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 90 days or the maximum benefit has been paid, whichever occurs first.

## MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses and Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her 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 the Plan Participant Person's attending Physician determines further Inpatient postpartum care in not necessary for the Plan Participant or her newborn Child provided the following are met:

1) In the opinion of the Plan Participant Person's 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:
    a) The antepartum, intrapartum, postpartum course of the mother and infant;
    b) The gestational stage, birth weight, and clinical condition of the infant;
    c) The demonstrated ability of the mother to care for the infant after discharge; and
    d) The availability of post discharge follow up to verify the condition of the infant after discharge; and

2. One (1) at-home post delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
    a) Parent education;
    b) Assistance in training in breast or bottle feeding; and

c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

## MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

## BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such confinement must be in a licensed or certified facility, including Hospitals.

## BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

**Biologically Based Mental Sickness** means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

a) Schizophrenia;

b) Schizoaffective disorder;

c) bipolar affective disorder;

d) major depressive disorder;

e) specific obsessive-compulsive disorder;

f) delusional disorders;

g) obsessive compulsive disorders;

h) anorexia and bulimia; and

i) panic disorder.

## ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

## BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement. Such Confinement must be in a licensed or certified facility, including Hospitals.

## BENEFITS FOR OUTPATIENT ALCOHOL and DRUG SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

**Alcohol Abuse** means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Drug Abuse** means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Detoxification Facility** means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

a) monitoring the amount of alcohol and other toxic agents in the body of the individual;

b) managing withdrawal symptoms; and

c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

## ELECTIVE/THERAPEUTIC TERMINATION OF PREGNANCY BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses incurred for the intentional termination of pregnancy before the fetus can live independently.

## EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to sustaining an Injury to natural teeth. We will pay benefits as described in the Schedule of Benefits for expenses incurred during the Plan Participant's Trip for emergency dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered.

## PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means c**harges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist , up to up to the maximum amount shown in the Schedule of Benefits per day for the Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, massage or any form of physical therapy.

## DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date**.** If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by

Us. We do not pay for the replacement of Durable Medical Equipment.

**Durable Medical Equipment** which includes braces and appliances means medical equipment that:

1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2) can withstand long-term repeated use without replacement;
3) is not useful in the absence of an Injury or Sickness; and
4) can be used in the home without medical supervision.

## ATHLETIC SPORTS BENEFIT

Coverage is provided up to the maximum amount payable as stated in the schedule if the Plan Participant's Injury or Sickness results from the below enumerated Athletic Sports & Hazardous activities:

1) Intercollegiate Sports

## OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, co-payment, and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

**Prescription Drug** means a drug which:

1) Under Federal law may only be dispensed by written prescription; and
2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

1) On or after the Plan Participant's Effective Date; and
2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

## EXCLUSIONS & LIMITATIONS

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

1) War or any act of war, declared or undeclared;
2) Injury sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
3) Voluntary, active participation in a riot or insurrection;
4) Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance;
5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;
6) For any Covered Losses resulting from the Plan Participant's intoxication or use of illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the Plan Participant's Physician;
7) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
8) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
9) Treatment of acne;
10) Charges which are in excess of Usual, Reasonable and Customary charges;
11) Charges that are not Medically Necessary;
12) Charges provided at no cost to the Plan Participant;
13) Expenses incurred for treatment while in Your Home Country;
14) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
15) Regular health checkups; routine physical, immunizations or other examination where there are no objective indications or impairment in normal health; unless specifically covered by this Policy.
16) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
17) Duplicate services actually provided by both a certified nurse midwife and Physician;
18) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
19) Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
20) Aggravation or re-injury of a prior Injury that the Plan Participant suffered prior to his or her coverage Effective Date, unless We receive a written medical release from the Plan Participant's Physician;
21) 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 except as specifically covered by the Policy;
22) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
23) Expense incurred for treatment of temporomandibular joint (TMJ) disorders or craniomandibular joint dysfunction and associated myofascial pain;
24) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident; unless otherwise specified in the Schedule of Benefits.
25) Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;

26) Weak, strained or flat feet, corns, calluses, or toenails;
27) Private-duty nursing services;
28) Expenses payable under any prior policy which was in force for the person making the claim;
29) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
30) Treatment paid for or furnished under any other individual or group policy, or other service or medical prepayment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for the treatment without cost to any individual;
31) Travel in or upon:
    a) A snowmobile;
    b) A water jet ski
    c) Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    d) Any off-road motorized vehicle not requiring licensing as a motor vehicle; when used for competition.
32) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; scuba diving, involving underwater breathing apparatus; solo diving snorkeling; spelunking; parasailing; white water rafting; surfing, unless part of a school credit course; and snow boarding.
33) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition; unless otherwise provided in the Schedule of Benefits;
34) Rest cures or custodial care;
35) Weight reduction programs or surgical treatment of obesity;
36) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);
37) Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
38) Travel or flight in or on any vehicle for aerial navigation except as a fare paying passenger on a regularly scheduled commercial airline.
39) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
40) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.
41) Treatment of HIV infection, HIV related illness and AIDS (acquired immune deficiency syndrome in excess of a lifetime maximum of $7,500).

# IMPORTANT INFORMATION REGARDING YOUR PLAN

***For Students:***

- Remember to keep your ID card with you and show it to all your medical providers. This will allow your medical providers to bill United Healthcare directly and if additional information is needed you will be notified.
- All medical expenses (bills) must be submitted within 12 months from the date of service or date of death, or they will be denied.
- To locate an in-network provider go to: United Healthcare Link
    - Scroll down and select "Options PPO Health Plan" or
    - "Prescription Benefits" for network pharmacies.
- If you have questions about your claim or need help locating a provider, please contact Robin Assist at 877-810-6870 or email eiia@robinassist.com. The Robin Assist Support Team is available 24/7.
- To file a claim or check on a claim status go to: **FILE A CLAIM**

***For Medical Providers***:

**United Healthcare Global**
**PO Box 30526**
**Salt Lake City, UT 84130-0526**
**Customer Service or Eligibility Verification: (877)559-5583 or online at:**
**https://www.uhcprovider.com/en/contact-us.html**
**EDI#: USN01**

***PLEASE NOTE: This plan does not require pre-authorization***

Insurance plans are underwritten by Crum & Forster SPC on and behalf of ITI SP. C&F and Crum & Forster are registered trademarks Crum & Forster SPC. The Crum & Forster group of companies is rated A (Excellent) by AM Best Company 2023.

All conditions of coverage, terms, and limitations are defined and provided for in the policy.

**Notice:** For further information on this Plan, visit www.eiia.org and click on STUDENT INSURANCE. Please keep this summary as a brief description of the important features of the plan. Benefits are provided for eligible Plan Participants. Terms and conditions are briefly outlined in this brochure. This plan contains both insurance and non-insurance benefits. Complete provisions pertaining to the insurance portion of the plan are contained in the policy. In the event of any conflict between this brochure and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of your plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to Capital University. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA compliant insurance coverage. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster SPC.

# SCHOLASTIC EMERGENCY SERVICES
# GLOBAL EMERGENCY ASSISTANCE SERVICE

Enrollment in the **International Student Accident & Sickness Plan** also provides you with a unique array of non-insurance global Emergency assistance when faced with a medical Emergency while traveling. Any time you are at least ***100 miles from your permanent address,*** campus address or in another country, the Scholastic Emergency Services program ensures that you have access to appropriate medical care.

Some of the many services offered include: medical consultations, prescription assistance, medical evacuation, medical repatriation, return of mortal remains, Hospital admission guarantee, Emergency trauma counseling, and pre-trip information. Should you experience a medical Emergency while traveling, call Scholastic Emergency Services and speak with trained crisis management counselors and medical personnel 24 hours a day, 365 days a year.

Scholastic Emergency Services does not replace your medical insurance. All medical costs incurred should be submitted to your medical insurance plan and are subject to the policy limits of your health insurance. **All assistance services must be arranged and provided by Scholastic Emergency Services. Claims for reimbursement of assistance services will not be accepted.**

This benefit applies only to students eligible students who have paid for this coverage and did not waive the coverage. Services are subject to verification of coverage. Once you are enrolled in the **International Student Accident & Sickness Plan** you may obtain an identification card and further information regarding the services provided by Scholastic Emergency Services from Health Services.

If you require assistance and are more than 100 miles from your permanent residence, campus, or abroad, call SES Operations Center at 1-877-488-9833 (toll free inside the U.S.A.) or 609-452-8570 (outside the U.S.A., precede number by U.S. access code). Please use Reference Number 01AA-EIA-05044.

*The Scholastic Emergency Services program is NOT INSURANCE and is solely provided by Scholastic Emergency Services and is not affiliated with Crum & Forster, SPC. Scholastic Emergency Services is a registered service mark of Assist America Inc.*

# PRIVACY POLICY AND PRACTICES

When used throughout this document “The Company”, “Our”, “We” or “Us” means: EIIA

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal, state and relevant international privacy laws (“Privacy Laws”). Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

**Your Privacy is Our Concern**
When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. The Company maintains physical, electronic, and procedural safeguards that comply with Privacy Laws to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information and takes measures to enforce employee privacy responsibilities.

**What kind of information do we collect about you and from whom?**
We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. We may use information about you from other transactions with us or our affiliates. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage, and we may contact you by phone or mail to obtain this. We may also obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

**What do we do with the information collected about you?**
We may use automated systems to make decisions based on your personal information, such as setting premium, and this helps us to be fair and efficient. If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

We keep the information we collect for the minimum period allowed by law. You have the right to ask us to delete or stop using your personal information if there is no need for us to keep it, but we may not be able to provide you with products or services if we do not have the information we require.

**To whom do we disclose information about you?**
We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

**How to contact Us**
You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator - EIIA 888-255-4029