

## Summary of Coverage

# Accident and Sickness Insurance

for



## Au Pair USA Program

Administered by:

### **TRAVEL INSURANCE SERVICES**

Walnut Creek, California

Policy No. GLB-9109322

Underwritten by:

The Insurance Company of the State of Pennsylvania  
Philadelphia, Pennsylvania  
A Member Company of American International Group, Inc.  
(AIG)

All participants of InterExchange, Inc.'s Au Pair USA Program whose names appear on file with the Company are insured under and subject to all definitions, exceptions, limitations, and provisions of the Master Policy on file with The Insurance Company of the State of Pennsylvania, Travel Insurance Services, and the Policyholder.

### **PERIOD OF COVERAGE**

1. Effective Date of Insurance: Coverage will begin upon the later of the following:
  - a) Departure from the Insured Person's home country;
  - b) Receipt of full premium by the Company.
2. Expiration Date of Insurance: Coverage will end on the earlier of the following:
  - a) The Insured Person's return to his/her home country;
  - b) Upon expiration of the coverage for which premium has been paid.

### **SCHEDULE OF BENEFITS**

\$75,000	Per Accident or Sickness Medical (\$30 Co-Pay Per Visit) (\$400 Emergency Room Visit Deductible)
\$10,000	Accidental Death & Dismemberment
\$30,000	Emergency Medical Evacuation
\$7,500	Repatriation of Remains
Included	Emergency Medical Assistance Service
Included	Family Travel Benefit

### **EMERGENCY MEDICAL ASSISTANCE SERVICE**

TO OBTAIN ASSISTANCE IN THE EVENT OF AN EXTREME EMERGENCY in which immediate emergency medical care is required, contact the 24-hour assistance service, Seven Corners Assist. Seven Corners Assist can recommend a local doctor or hospital, verify coverage, organize all emergency medical transportations, and provide multilingual assistance. Call toll free in the U.S. 1-800-690-6295 or collect from outside the U.S. 0-317-818-2808. When calling Seven Corners Assist, identify yourself as an InterExchange, Inc.'s Au Pair USA Program insured and refer to Policy No. GLB-9109322.

ALL EMERGENCY EVACUATIONS, FAMILY TRAVEL BENEFITS AND REPATRIATIONS ARE TO BE ORGANIZED THROUGH SEVEN CORNERS ASSIST.

## DESCRIPTION OF COVERAGES

### **ACCIDENT/SICKNESS MEDICAL – \$75,000**

When a covered Injury or Illness results, the Company will pay:

In Hospital Medical Services .....	100% of Covered Expenses
In Hospital Surgical Services.....	100% of Covered Expenses
Out of Hospital Medical Expenses.....	100% of Covered Expenses

\$30 co-payment per visit for out-patient hospital services and physician visits.

In no event shall the Company's maximum liability exceed \$75,000 per incident as to covered expenses during any one period of individual coverage.

**DEDUCTIBLE:** The \$400 Emergency Room Visit deductible is the dollar amount of covered expenses which must be incurred as an out-of-pocket expense by each Insured per emergency room visits. This deductible will be waived if the insured is admitted to the hospital.

### **Covered Expenses**

For the purpose of this section, only such expenses incurred as the result of and within 26 weeks from a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in the Exclusions section, shall be considered Covered Expenses:

1. Charges made by a hospital for room and board, floor nursing and other services, including charges for professional services, except personal services of a non-medical nature, provided, however, that expenses do not exceed the hospital's average charge for semi-private room and board accommodation, or two (2) times the average semi-private room charge made by the servicing hospital if confinement to an intensive care unit is required, or the actual charge for intensive care unit made by the servicing hospital, whichever is less;
2. Charges made for diagnosis, treatment and surgery by a physician;
3. Charges made for the cost and administration of anesthetics;
4. Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood trans-fusions, iron lungs, and medical treatment;
5. Charges for physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist;
6. Hotel room charge, when the Insured Person, otherwise necessarily confined in a hospital, shall be under the care of a duly qualified physician in a hotel room owing to unavailability of a hospital room by reason of capacity or distance or to any other circumstances beyond control of insured;
7. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a physician or Surgeon.

Coverages shall be excess of all other valid and collectible insurance indemnity. The charges enumerated above shall in no event include any amount of such charges which are in excess of regular and customary charges.

### **FAMILY TRAVEL BENEFIT**

1. The Company will pay the cost of a round-trip economy airline ticket to bring one person chosen by the Insured to and from the hospital or other medical facility where the insured is confined when, in the opinion of medical practitioner acceptable to the Company, such a visit is necessary due to a bodily injury or illness which constitutes an immediate danger to life.
2. In the event a parent, parent-in-law, child or sibling of a registered participant whose name is on file with the Company and who is living

in the registered participant's country of origin dies, the Company will pay the cost of a round trip economy airline ticket, not to exceed \$2,000, so that the registered participant can travel back to his or her country of origin. The registered participant must notify the Company of their family member's death within ten days from the date of death. Seven Corners Assist must make all arrangements for any benefit to be payable.

## EXCLUSIONS

No benefits shall be payable for medical expenses provided herein with respect to expenses incurred:

1. **For Pre-Existing Conditions, defined as any injury or illness which was contracted or which manifested itself, or for which treatment or medication was prescribed within ninety (90) days prior to the effective date of this insurance;**
2. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician;
3. For suicide or any attempt thereat while sane or self-destruction or any attempt thereat while insane;
4. Declared or undeclared war or any act thereof;
5. For injury sustained while participating in professional athletics;
6. For sickness resulting from pregnancy, childbirth, or miscarriage;
7. For miscarriage resulting from accident;
8. For routine physical or other examinations where there are no objective indications or impairment in normal health, and laboratory diagnostic or x-ray examinations except in the course of a disability established by the prior call or attendance of a physician;
9. For cosmetic or plastic surgery, except as the result of an accident;
10. For elective surgery which can be postponed until the insured returns to his/her country of residence;
11. For any mental or nervous disorders in excess of \$1,500 or rest cures;
12. For dental care, except as a result of injury to natural teeth caused by an accident, except for expenses up to \$75 per tooth for the removal of an impacted and/or abscessed wisdom tooth, or up to \$500 for expenses incurred for the emergency alleviation of dental pain (excluding routine restorations, amalgams or root canal therapy);
13. For eye refractions or eye examinations for the purpose of prescribing corrective lenses for eye glasses or for the fitting thereof, unless caused by accidental bodily injury incurred while insured hereunder;
14. In connection with alcoholism or drug addiction, or use of any drug or narcotic agent;
15. For congenital anomalies and conditions arising out of or resulting therefrom;
16. For expenses which are non-medical in nature;
17. For the ordinary cost of a one-way airplane ticket used in the transportation back to the insured's country where an air ambulance benefit is provided;
18. For expenses as a result of or in connection with intentionally self-inflicted injury;
19. For expenses as a result of or in connection with the commission of a felony offense;
20. For specific named hazards: motorcycle driving, scuba diving, mountain climbing, skydiving, professional or amateur racing, and piloting an aircraft;
21. Treatment paid for or furnished under any other individual or group policy, or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for treatment without cost to any individual.

## **ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)**

### **Principal Sum – \$10,000**

The Company shall pay an indemnity as determined from the Table of Losses below if an Insured Person sustains a loss stated therein resulting from injury, provided that such loss occurs within 365 days after the date of accident causing such loss. If more than one loss stated in the table below is sustained as the result of one accident, only one of the amounts so stated below, the largest, shall be payable.

#### **Table of Losses**

<b>Description of Loss</b>	<b>Indemnity</b>
For Loss of:	
Life.....	\$10,000
Both Hands or Both Feet or Sight of Both Eyes .....	\$10,000
One Hand and One Foot.....	\$10,000
Either Hand or Foot and Sight of One Eye .....	\$10,000
Either Hand or Foot .....	\$5,000
Sight of One Eye.....	\$5,000

The term “Loss” as used herein shall mean with regard to hands and feet, actual severance through or above wrist or ankle joints, and with regard to eyes, entire irrecoverable loss of sight. The aggregate limit of indemnity per accident is \$200,000.

## **EMERGENCY MEDICAL EVACUATION – \$30,000**

The Company will pay benefits for Covered Expenses incurred up to a maximum of \$30,000 if any injury or illness commencing during the course of a trip results in the necessary Emergency Evacuation of the Insured Person. An Emergency Evacuation must be ordered by a legally licensed Physician who certifies that the severity of the Insured Person’s injury or illness warrants the Emergency Evacuation of the Insured Person.

Emergency Evacuation means: a) the Insured Person’s medical condition warrants immediate transportation from the place where the Insured Person is injured or ill to the nearest Hospital where appropriate medical treatment can be obtained; or b) after being treated at a local Hospital, the Insured Person’s medical condition warrants transportation to his/her then current place of residence to obtain further medical treatment or to recover; or c) both a) and b) above.

Covered Expenses are expenses, up to the maximum, for transportation, medical services and medical supplies necessarily incurred in connection with Emergency Evacuation of the Insured Person. All transportation arrangements made for evacuating the Insured Person must be by the most direct and economical route. Expenses for special transportation must be: a) recommended by the attending Physician, or b) required by the standard regulations of the conveyance transporting the Insured Person. Expenses for medical supplies and services must be recommended by the attending physician. Transportation means any land, water or air conveyance required to transport the Insured Person during an emergency evacuation. Special transportation includes, but is not limited to air ambulances, and ambulances, and private motor vehicles.

**All emergency medical evacuations are to be organized through Seven Corners Assist.**

## **REPATRIATION OF REMAINS – \$7,500**

The Company will pay the reasonable covered expenses incurred to return the Insured Person’s body home (to his/her home country) if he or she dies, not to exceed the maximum of \$7,500.

All repatriation of remains are to be organized through Seven Corners Assist.

**With respect to Accidental Death & Dismemberment, Emergency Medical Evacuation, and Repatriation of Remains, the policy does not cover any loss, fatal or non-fatal, caused by, or resulting from:** 1) suicide or self destruction or any attempt thereat while sane or insane; 2) disease of any kind; 3) bacterial infections except pyogenic infection which shall occur through an accidental cut or wound; 4) hernia of any kind; 5) injury sustained in consequence of riding as a pilot, operator, or member of crew of any aircraft, except as a passenger; 6) declared or undeclared war or any act thereof; 7) service in the military, naval or air service of any country. With regard to Emergency Medical Evacuation and Repatriation of Remains, exclusions 2, 3, and 4 above shall be deleted.

## **DEFINITIONS**

The term “Hospital” as used herein shall mean, except as may otherwise be provided, a hospital (other than an institution for the aged, chronically ill or convalescent, resting or nursing homes) operated pursuant to law for the care and treatment of sick or injured persons with organized facilities for diagnosis and surgery and having 24-hour nursing service and medical supervision.

The term “Physician” as used herein shall mean a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform surgery in accordance with the laws of the state where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

The term “Injury” wherever used herein means bodily injury caused solely and directly by violent, accidental, external, and visible means occurring while the policy is in force and resulting directly and independently of all other causes in loss covered by the policy.

The term “Illness” wherever used herein means sickness or disease of any kind contracted and commencing after the effective date of the policy and causing loss covered by the policy.

## **HOW TO FILE A CLAIM**

Completed Claim Forms should be sent to: Seven Corners, Inc., 303 Congressional Blvd., Carmel, IN 46032. Carefully follow the detailed instructions listed on the I.D. Card.

*Policy terms and conditions are briefly outlined in this Summary of Coverage. Complete provisions pertaining to this insurance plan are contained in the master policy on file with the Insurance Company of the State of Pennsylvania, InterExchange, Inc. and Travel Insurance Services. In the event of any conflict between this Summary of Coverage and the master policy, the master policy will govern.*

**– CLAIM FORM –**

**The Insurance Company of the State of Pennsylvania  
A Member Company of American International Group**

Policyholder: INTEREXCHANGE, INC./AU PAIR USA PROGRAM  
Policy No.: GLB-9109322

1. Insured or Insured Person's representative must complete the following information. Be sure to sign and date this form.
2. In order to identify medical bills sent directly to the claims department from the medical provider, the Insured Person must also send the claims department an accurate and fully completed Claim Form immediately at the onset of each new Injury or Illness. Bills need not accompany Claim Form.
3. One of the following **MUST** be sent to the claims department:
  - a) The Physician's "Super Bill" or
  - b) A fully itemized statement of charges with diagnosis on the attending Physician's letterhead or regular billing.
4. This Claim Form and all bills must be submitted to:  
Seven Corners, Inc.  
303 Congressional Blvd.  
Carmel, IN 46032  
800-335-0477 or 317-575-2656
5. **IMPORTANT:** In order for claims to be processed, an accurately completed Claim Form must be submitted for each new Injury or Illness. If a Claim Form is incomplete or is not submitted, the claims department will either:
  - a) Return the incomplete Claim Form back to the U.S. address requesting further information; or
  - b) Return bills to the U.S. address for identification.

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

- 1) Name of Insured Person: \_\_\_\_\_
- 2) Date of Birth: \_\_\_\_\_
- 3) Permanent Residence: \_\_\_\_\_
- 4) Temporary Travel Address: \_\_\_\_\_
  
- Phone: \_\_\_\_\_
- 5) Date of accident or date Illness first appeared: \_\_\_\_\_
- 6) In which country did the accident or Illness occur? \_\_\_\_\_

7) Describe Injuries or Illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) If accident, how did it occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9) If Illness, have you had it before? \_\_\_\_\_  
When? Date of previous medical treatment: \_\_\_\_\_  
Are you on any medication to control this condition?  Yes  No

10) Name and address of attending Physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11) Check should be sent to:  Physician  Hospital  Insured  
 InterExchange, Inc.

This insurance coverage is in excess over other insurance. Are there medical benefits available from any other source?  Yes  No

If yes, name and organization and policy or plan available:  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Policy No. \_\_\_\_\_

**MEDICAL INFORMATION RELEASE**

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

\_\_\_\_\_  
Signature of Insured Person or Representative

\_\_\_\_\_  
Date