

2010 Insurance Information & Claim Form

International YMCA

*International Camp Counselor Program (ICCP)
Summer Work Travel Program, Global Programs*

Policy No. 50205016808032001

As a participant in a YMCA sponsored program which includes accident and sickness insurance, this brochure outlines the basic provisions of coverage in force and available to you.

PERIOD OF COVERAGE

Coverage is in force from the day of departure from the participant's place of domicile through the conclusion of the program.

NATURE OF COVERAGE

Death Benefit (\$20,000) -- If, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay the death benefit less any specific loss benefit paid because of the same accident.

Specific Loss Benefit (Face Amount \$20,000) – If, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay:

Each Arm	\$15,000.00
Each Leg.....	15,000.00
Each Hand	10,000.00
Each Foot.....	10,000.00
Sight of Each Eye.....	10,000.00
Speech.....	10,000.00
Hearing of Each Ear	5,000.00
Thumb & Index Finger of Same Hand.....	5,000.00

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

Accident & Sickness Medical Expense Benefit (\$100,000 Maximum Limit, \$10 deductible per accident) -- If, as a result of injury or sickness, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury or the date sickness begins, we will pay, less the \$10 deductible and not to exceed the overall maximum benefit amount, all covered expenses incurred within 3 years from such dates.

Covered expenses means the reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following reasonable and customary charges for treatment, services and supplies provided or prescribed by a doctor:

- 1) hospital or surgical center care;
- 2) medical treatment;
- 3) nursing care provided by a licensed nurse;
- 4) X-rays and lab exams;
- 5) prescription drugs and therapeutic services and supplies;
- 6) dental treatment as a result of injury to sound, natural teeth; and
- 7) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or skilled nursing home confinement:
 - a) physical, occupational, respiratory and speech therapy,
 - b) the services of a home health aide and
 - c) medical supplies.

As excess medical has been elected, we will not pay benefits for, nor can this plan's deductible be satisfied by, covered expenses to the extent that they are collectible under certain other policies and/or health plans as stated in the policy.

Maternity Expense Benefit -- We will pay, subject to all other provisions of the Policy applicable to sickness, the charges for Covered Expenses incurred as a result of pregnancy, including resulting childbirth, abortion or miscarriage. Benefits are payable for charges made by:

- a) a physician for the performance of an obstetrical procedure and examination;
- b) a Hospital for medical care and treatment, including room and board and floor nursing care;
- c) an anesthetist or by a Hospital for the cost and administration of anesthetics;
- d) a professional ambulance service;

Pregnancy must commence after you become a participant in the YMCA Program and while the coverage is in force.

Psychiatric Care Benefit – We will pay, subject to all other provisions of the Policy applicable to sickness, the charges for Covered Expenses incurred for psychiatric care on an inpatient or outpatient basis.

TRAVEL ASSISTANCE SERVICES PROVIDED BY ON CALL INTERNATIONAL (OCI)

If you are traveling and have an emergency, contact the 24/7 call center at 800-407-7307 (toll-free from the U.S. or Canada) or 603-898-9159 (call collect from anywhere in the world).

Emergency Evacuation (\$50,000 Combined Single Limit) -- If you or your dependent suffer an Injury or Sickness and adequate medical facilities are not available locally in the opinion of OCI's Medical Director, OCI will provide emergency evacuation (under medical supervision if necessary) by whatever means necessary to the nearest facility capable of providing adequate care. Services include arranging and paying for transportation and related medical services (including cost of medical escort) and medically necessarily incurred in connection with the emergency evacuation.

Medically Necessary Repatriation (Included in the CSL) -- After initial treatment and stabilization for an Injury or Sickness, if the attending Physician and OCI's Medical Director deem it medically necessary, OCI will transport you back to your permanent place of residence for further medical treatment or to recover. Services include arranging and paying for transportation and related medical services (including escort, if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Repatriation of Mortal Remains (\$7,500 Maximum Coverage Limit) -- In the event of your death, OCI will render assistance and provide for the return of mortal remains. Services include arranging and paying for the following: location of a sending funeral home; transportation of the body from the site of death to the sending funeral home to the airport; minimally necessary casket or air tray for transport; coordination of consular services (in the case of death overseas); procuring death certificates; and transport of the remains from the airport to the receiving funeral home. Other services that might be performed in conjunction with those listed above include: making travel arrangements for any traveling companions; identification and/or notification of next-of-kin.

Visit by Family Member or Friend (\$2,500 Maximum Coverage Limit) -- If you are hospitalized for more than seven (7) days and are traveling alone, OCI will arrange and provide your family member or friend with transportation to visit you.

EXCLUSIONS FROM COVERAGE

This policy does not cover the following:

1. Eyeglasses or prescription therefor, or equipment for corrective treatment of sight.
2. Special appliances, except as noted in section B and C above.
3. Transportation costs, except ambulance service.
4. Suicide, or the attempt thereat, while sane or insane.
5. Injury occurring in a plane other than while riding as a passenger in a licensed passenger aircraft operated by a licensed commercial pilot, or hang-gliding apparatus, or parachuting.
6. Dental treatment, dental X-rays, dentures, except for accidents to sound, natural teeth.
7. Health treatments where no injury or sickness is involved.
8. Expenses covered by other insurance.
9. Loss caused by war or any act of war.
10. Any Injury or Sickness which originated prior to the effective date of the insured person's coverage and which has been under treatment during a period of less than thirty-one (31) days immediately preceding that date.

TERRITORIAL LIMITATIONS

This policy covers only injury and sickness while the Insured Person is engaged in a trip away from his or her place of domicile.

NOTICE OF CLAIMS

All claims must be processed through Nationwide Insurance. Duplicate copies of the claim forms (provided by YMCA or obtainable by writing to Nationwide Insurance) should be submitted, together with particulars fully substantiating each claim, immediately after the date of the accident or commencement of illness, and in any case, before departure, if possible. If available, bills for initial expenses should be sent to Nationwide Insurance with the claim forms. All subsequent bills should be likewise sent. All charges must be substantiated with statements submitted by doctors, hospitals, pharmacies, etc. before payment on a claim can be made.

Please refer to the instructions for completion on the back of each claim form.

A detailed explanation of the coverage provided by Nationwide Insurance is contained in the master policy filed at offices of the YMCA Headquarters and is available during office hours.

Instructions for YMCA Claim Form
Policy No. 50205016808032001
International Camp Counselor Program (ICCP), Summer Work Travel Program, Global Programs

1. Be sure to fill in the name and address of the physician, even though you may not be submitting his or her bill at this time.
2. Be sure to sign the claim form and fill in the date when you mail to the company.
3. Enclose all bills and duplicates that you have pertaining to the illness or injury. Mail the claim form and all bills to:

Nationwide Insurance Claims Department
P.O. Box 420
Springfield, MA 01104-0420

4. It is best to submit all bills for an illness or injury at the same time. However, if there is a delay in your receiving a bill or if your case will require extended or repeated treatment, file a claim as soon as possible after treatment, and send in the bills as you receive them. In this case, please indicate below that additional bills are to follow, giving details if possible. **IN NO CASE SHOULD YOU DELAY BEYOND 10 DAYS AFTER THE TERMINATION OF YOUR PROGRAM BEFORE SUBMITTING A CLAIM.**

Questions? If you have any questions about your insurance, please call Nationwide Insurance from within the United States at 800-525-8669 and choose Option 3 for Customer Service. If you are calling from outside the United States, call 001-413-733-4540 and choose Extension 166. You can also email Nationwide Insurance at customerservice@consolidatedhealthplan.com.

Name of insured _____ Social Security Number (if applicable) _____

Home country address _____

Home country phone number _____ Home country email address _____

Name of parent or guardian if claimant is under 21 _____

USA work location name and address _____

USA home address _____

USA home or cell phone _____ USA email address _____

Date of illness or accident _____ Name of illness or injury _____

If illness, have you had it before? _____ When? Date of last medical treatment _____

If accident, how did it happen? _____

If accident, is it job related Yes _____ No _____ If Yes, is coverage available under your employer's Worker's Compensation insurance? _____

If No, your employer must enclose a letter of denial from his or her Worker's Compensation insurance company so that we may process the claim.

Do you, your spouse or your dependents have any other insurance or medical plan that covers this condition? Yes _____ No _____

If Yes, please provide the name of the insurance company _____

PHYSICIAN, SURGEON OR HOSPITAL AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended me or examined me, to furnish to Nationwide Insurance or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature _____

Date _____