This is a Description of Coverage for

United Work and Travel, Inc.

a Division of American Pool Enterprises, Inc.

Underwritten By: Markel Insurance Company (Herein Referred to as "the Company")

Eligibility: You will be covered under this plan if you are participating in the work & travel programs conducted by United Work and Travel, Inc.

Period of Coverage: Coverage will begin: a) for Accidental Death & Dismemberment Benefits, the time of departure from the Insured's point of last domicile or temporary residence in their Home Country directly to the point of embarkation on the scheduled program of United Work and Travel, Inc; and b) for all other benefits, the time of the insured's departure from their Home Country. Coverage will end: a) for Accidental Death & Dismemberment Benefits, the time of return to the Insured's domicile or temporary residence in their Home Country directly from the point of disembarkation from the scheduled program of United Work and Travel, Inc. for benefits and b) for all other benefits, the time of arrival in the Insured's Home Country. This insurance only covers the participant while he/she is participating in an intern program at the direction and expense of United Work and Travel, Inc.

Definitions: Sickness: Means an Illness, disease or condition of the Insured that causes a loss which an insured incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness. **Injury:** means accidental bodily harm sustained by an Insured that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. **Home Country:** means a country from which the insured holds a passport. If the Insured holds passports from more than one country, his or her Home Country will be that country which the Insured has declared to the Company in writing as his or her Home Country. **Medically Necessary:** means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a doctor or furnished by a Hospital; 2) performed in the least costly setting required by the Insured's condition; and 3) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used, The Company may, at its discretion, consider the cost of the alternative to be the Covered Expense.

Medical Expense Benefits: If a covered Injury or Sickness occurs during the Period of Coverage and the Insured requires medical or surgical treatment, The Company will pay:

Medical Expense	In Network	Out of Network
$1 - $2,500	Paid at 100% of negotiated fee	Paid at 90% of Usual & Reasonable
$2,500 - $10,000	Paid at 80% of negotiated fee	Paid at 70% of Usual & Reasonable
$10,000 - $100,000	Paid at 100% of negotiated fee	Paid at 90% of Usual & Reasonable

In no event will: (1) the Company's liability exceeds $100,000 for each covered Injury or Sickness; and (2) Covered Expenses exceed the usual and customary expenses for the geographical area where the services are rendered, as determined by the Company. Outpatient prescription drug expenses is 100% inpatient and 100% outpatient subject to a $25 deductible per prescription.

Deductible: (The dollar amount for which you are responsible and after which policy benefits will be paid)

$150.00 per accident or sickness per Physician visit

Emergency Room

$ 100.00 deductible to maximum of $500 – Injury only - Outpatient

$ 250.00 per accident or sickness if admitted to the hospital

To be considered a Covered Expense under this plan, it must: a) have been incurred as the result of and within 52 weeks of a covered Sickness or Injury outside of the Home Country during the Period of Coverage; b) not be excluded by provisions of this Plan; and c) be specifically included in the following list of expenses:

1. Expenses made by a hospital for room and board, including registered nursing services and any other medically necessary hospital services, but not including personal services of a non-medical nature. However, allowable expenses may not exceed the hospital's average charge for semiprivate room and board accommodation.
2. Expenses made for diagnosis, treatment and surgery by a doctor.
3. Expenses made for the cost and administration of anesthetics.
4. Expenses for x-ray services, laboratory tests and services
5. Expenses for durable medical equipment (includes rehabilitative braces and appliances, both inpatient and outpatient).
6. Expenses for Physiotherapy, if recommended by a doctor for the treatment of a specific disablement administered by a licensed physiotherapist, subject to a maximum benefit 20 days per policy year, inpatient only.
7. Expenses for prescription drugs including dressings, drugs, and medicines prescribed by a doctor, 100% inpatient and 100% outpatient subject to a $25 deductible
8. Expenses for dental expenses resulting from an injury to sound, natural teeth, up to; $1,000 maximum benefit per occurrence; Alleviation of Pain; Maximum Benefit $500 per occurrence.
9. Outpatient surgery & related ancillary expenses – maximum of $1500

Emergency Medical Evacuation Benefit: The Company will pay Emergency Medical Evacuation Benefits up to the maximum of $500,000 for expenses incurred for the medical evacuation of an Insured. Benefits are payable if the Insured: 1) is traveling outside his or her Home Country; 2) suffers an Injury or Sickness during the course of the Trip; and 3) requires Emergency Medical Evacuation. Benefits will not be payable unless: 1) the doctor ordering the Emergency Medical Evacuation certifies the severity of the Insured's Injury or Sickness requires an Emergency Medical Evacuation; 2) all transportation arrangements for the Emergency Medical Evacuation are by the most direct and economical conveyance and route possible; 3) the charges incurred are Medically Necessary and do not exceed the usual level of charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and 4) do not include charges that would not have been made if there were no insurance. "Emergency Medical Evacuation" means; 1) the Insured's immediate transportation from the place where he or she suffers an Injury or Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained; or 2) the Insured's transportation to his or her Home Country to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness. An Emergency Medical Evacuation also includes Medically Necessary medical treatment, medical services and medical supplies necessarily received in connection with such transportation. An Emergency Medical Evacuation of an Insured to their Home Country will terminate all benefits except Accidental Death and Dismemberment Benefits under the plan. **All arrangements must be made by the Assistance Provider and approved by the Company in order for expenses to be considered eligible.**

Repatriation of Remains: The Company will pay the usual and customary covered expenses, up to a maximum of $500,000, to return an Insured's body home to his or her Home Country if he or she dies while covered by this plan. Covered expenses include, but are not limited to, expenses for embalming, cremation, coffins and transportation. **All arrangements must be made by the Assistance Provider and approved by the company in order for expenses to be considered eligible.**

Emergency Reunion Benefit:

For Hospital Stay or Felonious Assault

Total Benefit Maximum:	**$12,500**
Daily Benefit Maximum:	**$300**
Maximum Number of Days:	**10**

For Repatriation of Remains

Total Benefit Maximum:	**$2,500**

Accidental Death and Dismemberment Benefit: If an insured's covered Injury results in any of the following losses within 365 days after the date of accident, the Company will pay the sum shown opposite the loss. The Company will not pay more than the Principal Sum for all loses due to the same Accident.

Principal Sum: $15,000

Description of Loss	Indemnity
Life, Both Hands or Both Feet or Sight of Both Eyes, One Hand and One Foot, Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot or Sight of One Eye	One-Half the Principal Sum
Thumb and Index Finger of the same hand	One-Quarter the Principal Sum

The term "loss" as used herein shall mean, with regard to hands and feet, actual severance through and or above wrist or ankle joint and with regard to eyes, entire irrecoverable loss of sight. "Severance" means complete separation and dismemberment of the part of the body.

Excess Benefits: All benefits, except Accidental Death and Dismemberment, shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted.

Exclusions and Limitations:

With Respect to Medical Expense, Emergency Evacuation & Repatriation of Remains, Emergency Reunion, Benefits, no benefit shall be payable with respect to expenses incurred:

1. For pre-existing conditions (defined as a Sickness, disease or other condition, of the Insured, that in the 6 month period before the Insured's coverage became effective under the Policy: 1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care or treatment; or 2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3) was treated by a doctor or treatment had been recommended by a doctor. Losses incurred for Pre-existing Conditions are covered under this plan provided the Insured demonstrates that they had continuous insurance coverage for 6 months prior to becoming insured under this plan. After the Pre-Existing Condition requirement is met, coverage will be considered continuous provided there is not a break in coverage. (This pre-existing condition exclusion does not apply to the Emergency Medical Evacuation, Emergency Reunion or Repatriation of Remains Benefits).
2. For services, supplies, or treatment including any period of hospital confinement, which was not recommended, approved and certified as necessary and reasonable by a doctor, or expenses which are non-medical in nature.
3. For loss incurred as a result of war or any act of war, whether declared or not.
4. For Injury sustained while participating in professional, intercollegiate sports or interscholastic sports.
5. For routine physicals and immunizations.
6. For cosmetic surgery, except as the result of an injury.
7. For elective surgery.
8. For dental care, except as provided in the Policy.
9. For 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 while insured hereunder.
10. For expenses as a result of, or in connection with, intentionally self-inflicted injury.
11. For suicide or attempted suicide while sane or insane.
12. For expenses as a result of, or in connection with, the commission of or attempt an assault or a felony.
13. For scuba diving, jet and water skiing, mountain climbing (where ropes or guides are normally used), skydiving, and professional or amateur racing.
14. For treatment furnished under any mandatory government program or facility set up for treatment without cost to any individual.
15. Injury or Sickness covered by Worker' Compensation, Employer's Liability Laws or similar occupational benefits.
16. For treatment by an immediate family member.
17. For alcoholism or drug addiction or use of any drug or narcotic unless prescribed by a doctor.
18. For Loss incurred as a result of pregnancy and childbirth. (does not include complications of pregnancy.
19. Treatment for or related to any congenital condition.
20. For charges for use of Emergency Room for treatment of Injury or Sickness unless the patient is directly admitted to the Hospital as an Inpatient for further treatment of that Injury or Sickness.
21. For mental health disorders or substance abuse.
22. Which are not incurred during the Insured's period of coverage and charges that are not remitted for payment within 60 days from the end day of the Insured's Termination Date of Insurance.
23. For Physiotherapy expenses on an outpatient basis.
24. For not medically necessary and not administered or ordered by a Physician.
25. Which exceed the Usual and Customary charge.
26. For investigational, experimental or for research purposes.
27. While confined to primarily receive custodial care, educational or rehabilitative care.
28. For venereal disease and treatment of HIV or AIDS.
29. For chiropractic care.
30. For diseases of the skin.
31. For treatment required as a result of complications or consequences of a treatment or condition not covered hereunder.
32. Charges for travel or accommodations.
33. Organ or tissue transplants or related services.

For the Accidental Death and Dismemberment Benefit, this Plan does not cover any loss, fatal or non-fatal; caused by or resulting from:

1. Intentionally self-inflicted injury.
2. Suicide or attempted suicide, while sane or insane.
3. War or act of war, whether declared or not.
4. Service in the military, naval, or air service of any country.
5. Sickness, Disease, or infection of any kind, except bacterial infections due to an accidental cut, wound, botulism or ptomaine poisoning.
6. Piloting or acting as a crewmember or riding in any aircraft; except as a fair paying passenger on a scheduled airline.

Claims Administrators: MCA Administrators, Inc.; PO Box 6540; Harrisburg, PA 17112 Toll Free 1-800-427-9308 • Fax 717-652-8328.

A CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM.

Preferred Provider Organization: NHBC – 888-621-7900. http://providers.nhbc.com Access code: AMA411

Emergency Assistance: AXA Assistance USA 1 (888) 735-8473. In addition to this health insurance program is access to the 24-hour Assistance network for emergency assistance anywhere in the world. Simply call the assistance center at AXA Assistance USA toll–free, using the telephone number listed above. The multilingual staff will answer your call and provide reliable, professional and thorough assistance. The following services are included in the program: referral to the nearest most appropriate medical facility and/or provider, medical monitoring by board-certified emergency doctors in the United States; urgent message relay between family, friends, personal doctor, school, and insured; guarantee of payment to provider and assistance in coordinating insurance benefits; arranging and coordinating Emergency Medical Evacuations, and Repatriation of Remains; Emergency travel arrangements for disrupted travel as the consequence of a medical emergency; referral to legal assistance; assistance in locating lost or stolen items including lost ticket application processing.

Program Arranged By: Markel Insurance Company. Policy Number: 11200713 Effective 11/20/2011 Terminates 11/20/2012
Claim forms and instruction are available from the website: www.amastudentplans.com

This Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in 11200713. The policy is subject to the laws of the state in which it was issued (Maryland). Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.

Return Completed form to:
MCA Administrators, Inc.
P.O. Box 6540
Harrisburg, PA 17112
P:800-427-9308 | **F**:717-652-8328

College Insurance Claim Form

Instructions for Filing a Claim

1. Complete this form (including the appropriate signatures).
2. Attach all itemized bills relating to the claim.
3. Submit the completed form and bills to the address or fax number listed above.
4. Social Security Number is required for Federal reporting.

Claim procedures, online access t o our claim form, and our privacy policy are available from our website at: **www .MarkelAH.com**

STUDENT INFORMATION

College (or) University United Work & Travel	Policy Number 11200713			Student ID	Soc Sec Num
Student's Name	Student's Gender ☐ Male ☐ Female			Student's Date of Birth	
If claim is for dependent, give name and relation Spouse ☐ Child ☐	Dependent's Gender ☐ Male ☐ Female			Dependent's Date of Birth	
Student's Full Address While At School	City	State	Zip	Phone Number	
Student's Home Address	City	State	Zip	Phone Number	

1. Date of injury or beginning of sickness ______________ Date physician first consulted ______________

2. Type of injury or sickness ______________

3. If pregnancy, please indicate your last menstrual period (LMP) date ______________

4. If Injury: a. How did the accident occur? ______________

b. Where did the accident occur? ______________

c. Were you practicing or playing a college sport at the time of injury? ☐ Yes ☐ No

Select Type: ☐ Intramural ☐ Intercollegiate ☐ (between rival colleges) Name of Sport ______________

d. For an intercollegiate sport injury, the following must be completed and signed by a representative from the athletic department: Was the injured involved in any activity under the jurisdiction of the Policyholder? ☐ Yes ☐ No

Under whose supervision? ______________

Representative Signature ______________ Title ______ Date ______

5. Were you treated by the Student Health Service? ☐ Yes ☐ No - If "Yes" date(s) treated ______________

Were you referred by the Student Health Service? ☐ Yes ☐ No - If "Yes" date referred ______________

If "No," was the Student Health Service closed? ☐ Yes ☐ No

6. Have you suffered the same or similar condition in the past? ☐ Yes ☐ No - If "Yes" please provide the name and address of the physician who treated you: ______________ Dates Treated ______________

7. Do you, your dependents, or your parents have any other insurance that would cover this condition? ☐ Yes ☐ No

If "Yes," indicate the name of the insurance company ______________

8. Is the condition due to an injury or sickness arising out of your employment? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to the insured.

Claimant, Parent or Authorized Representative's Signature: ______________ **Date:** ______________

If Authorized Representative, Relationship to Patient or Legal Designation: ______________

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.
I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC. I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent or Authorized Representative's Signature: ______________ **Date:** ______________

If Authorized Representative, Relationship to Patient or Legal Designation: ______________

PLEASE NOTE

In furnishing this or other claim forms fro the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights.
MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

FRAUD STATEMENTS

GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Medical ID Card

UNITED WORK & TRAVEL, INC.
A division of American Pool Enterprises, Inc.

NHBC
Total Savings Solutions

Policy # 11200713 Valid only for the dates of your approved program.

To verify eligibility, call Member Services.

For Member Services or Claims contact:
MCA Administrators, Inc. (800) 427-9308
PO Box 6540 Harrisburg, PA 17112
For Providers call: 1-888-621-7900 or go to:
http://providers.nhbc.com use ID# AMA411

$150 Deductible per Doctor Visit

Emergency Room
$100 Deductible to max of $500 (outpatient injury)
$250 Deductible if admitted (injury or sickness)
NO BENEFITS for Outpatient SICKNESS visit

Underwritten by:
Markel Insurance Company

Travel Assistance provided by:
AXA Assistance USA
1-888-735-8473

For claim form and more info: www.amastudentplans.com/uwt

Possession of this card does not guarantee coverage.

Providers can verify eligibility by contacting MCA Administrators, Inc. at (800) 427-9308

To reprint this card, go to www.amastudentplans.com/uwt

PPO Network Card

NHBC
Total Savings Solutions
NSAP
National Student Accident Program

For National Access when outside of the Primary PPO service area, present this card along with your primary medical ID card.
Please DO NOT DISCARD your primary medical ID card.
To Locate Providers: Use NHBC group ID #: AMA411
888-621-7900 http://providers.nhbc.com
This Card does not prove membership nor guarantee coverage.
For verification of benefits, please contact member services listed on your primary medical ID card.

FHN: AK, CA FL, GA, IA, ID, KS, MA, ME, MS, NE, NV, OK, OR, SC, UT, WA
HCAL: AL
HFN: IL
AZ Foundation: AZ
Interplan: WI
HealthSmart: TX
MultiPlan: HI
America'sPPO: MN, ND, SD
PHCS: CT, KY, LA, MO, NH, NJ, NM, NY, OH, RI, VT, WV
Encore: IN
Cofinity: CO, MI
OneNet: DC, MD, NC, VA
InterWest Health: MT, WY
Devon: DE, PA
AmericanPPO: AR
Bluegrass Family Health Single Source: Middle/West TN
Health Partners: West TN
The Initial Group: East TN
NHBC
Claims: Submit to address on primary medical ID Card.

Directions to Search for a Provider

Go to http://providers.nhbc.com to locate a provider

On the Welcome Page, click

Click here if you are seeking medical services OUTSIDE your home state…

On the next page

Enter your group ID: AMA411

Choose the State from the drop down menu and click "Go To Directory".

On the next page

Click on your choice:

To find doctors or physicians = **Find a Healthcare Provider.**

To find hospitals = **Find a Hospital**

For Urgent Care Clinics and Similar facilities = **Find Other Facility**

If using the Location Search

Insert City OR County ONLY. Do not use Zip Code

Click Search

A list of participating providers, within the criteria you chose, will be displayed on the screen. If there are no participating providers within the range you have chosen, you can expand your options to see other possible providers.

If using the Proximity Search

Click the radio button next to Proximity Search

Enter Zip Code ONLY

Set Distance to the range with which you are willing to travel.

Click Search

A list of participating providers, within the criteria you chose, will be displayed on the screen. If there are no participating providers within the range you have chosen, you can expand your options to see other possible providers.

Optional Search Information

You can choose a specialty or type of facility to only see providers in that field of medicine. You can also use the name search if you want to search for a specific doctor that is part of a larger practice.

In all of the Provider Listings you are given, Name, Address, Phone number and a map to their office.

For Assistance Locating Providers, Please call – 888-621-7900