

# LEWERMARK

medical benefits plan for international students

## COVERAGE FOR INTERNATIONAL STUDENTS THAT EVERYONE CAN UNDERSTAND

### *Making a World of Difference*

#### Benefits for Accident and Sickness

- Medical evacuation benefit
- Repatriation benefits
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**Insured By:**  
**Great-West Life & Annuity Insurance Company**

### ELIGIBILITY

The LewerMark International Student's Medical Benefits Plan is designed for international and practical training students and their dependents. The Plan is available by virtue of a master blanket insurance policy issued by the Company, Great-West Life & Annuity Insurance Company, to a university, college or other educational organization (the "policyholder").

An "Eligible Student" means any international and practical training student of the Policyholder who all of the following:

1. is enrolled and actively engaged full-time, as defined by the Policyholder in accordance with applicable United States law, in educational activities.
2. is temporarily outside his/her home country or country of regular domicile as a non-resident alien, or a non-domiciled United States citizen with dual citizenship, in the United States.
3. has a current passport and applicable current student visa or other non-immigrant visa which allows the individual to enroll in a course of study (non-domiciled United States citizen – passport only).
4. maintains non-immigrant status under the applicable visa type according to applicable United States law.

For purposes of Item 1. above, eligible students taking a term or semester break (herein referred to as "term break"), annually, in accordance with school policy and while keeping coverage in force are considered Eligible Students engaged in full-time educational activities.

For schools with a two-semester term system, summer break is the designated term break. For schools with a trimester or quarter term system, any trimester or quarter can be taken as the term break, provided only one trimester or quarter is taken per academic calendar year.

The following do not count toward fulfilling the full-time status Eligibility requirement:

1. home study.
2. correspondence courses.
3. internet courses.
4. television courses.

International students who have applied for permanent residency in the U.S. in accordance with federal law in effect at the time of enrollment, are not Eligible Students.

**Eligible Dependent** means any dependent of an Eligible Student who meets all of the following:

1. is the Eligible Student's lawful spouse; or is the Eligible Student's unmarried Child under age 19; or is the Eligible Student's unmarried Child under the age of 25 if:
  - the Child is a full-time student, or
  - the Child has the same legal residence as the Eligible Student, or
  - the Child is financially dependent upon the Eligible Student
2. is enrolled for coverage under the Policy at the same time the Eligible Student enrolls;
3. has a current passport and visa (non-domiciled United States citizen-passport only) ; and
4. is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien or a non-domiciled United States citizen with dual citizenship, in the United States.

Dependent Children born in the United States and disabled, unmarried Children age 19 and over (exceptions apply) are also Eligible Dependents.

### COVERAGE PERIOD

Provided the correct premium is received timely and the Eligible Student and/or Eligible Dependent is properly enrolled, coverage will be effective:

1. on the first day of the school term for which coverage is applied for if the Eligible Student became an Eligible Student on the first day of the school term and applies within the first 60 days of the school term.
2. on the first day of becoming an Eligible Student if such day is after the first day of the school term, and enrollment is made within 60 days of becoming an Eligible Student.
3. for an Eligible Student who is eligible for Extended Coverage, and his/her Eligible Dependents, 30 days prior to the first day of the school term if the Eligible Student applies for coverage within the first 60 days of the school term.
4. on the first day an Eligible Student or Eligible Dependent suffers an involuntary loss of other coverage if such day is after the first day of the school term, and enrollment is made within 60 days of such loss.
5. on the first day of the next school term if enrollment is made more than 60 days after becoming an Eligible Student or after becoming an Eligible Dependent, or after an Eligible Student or an Eligible Dependent suffers an involuntary loss of other coverage.

6. for an Eligible Dependent Child, on the date of birth, adoption or Placement for Adoption, if enrollment is made within 31 days of such event.
7. for an Eligible Dependent, on the first day of the first month following the Dependent's initial eligibility date for dependents joining an Insured Student's family through marriage or other court decree while the Insured student is covered under the Policy.
8. for an Eligible Dependent, on the first day of the first month following the date the Dependent first meets the definition of "Eligible Dependent" if such Dependent did not qualify at the time the Insured Student was enrolled under the Policy. Enrollment must be made within 31 days of becoming eligible.

Dependent coverage cannot become effective prior to the effective date of the Eligible Student's coverage.

Coverage will automatically terminate on the earliest of:

1. The date the Policy terminates.
2. The last day of the period for which premium has been timely paid according to Policy provisions.
3. The date the Insured Individual is no longer eligible for coverage.
4. For an Insured Individual under Extended Coverage, upon the Eligible Student's graduation or completion of an educational program and in preparation for the resulting departure from the United States, coverage will terminate 30 days following graduation or completion of an educational program, provided the student and his or her covered Dependents remain in the United States during that 30-day period.
5. The date requested by the Insured Individual approved by the Policyholder in writing that is no sooner than 5 days after the date the Company or its authorized administrator receives written notice.
6. The date the Insured Individual departs the United States for the Student's home country or country of regular domicile.

**To avoid a break in coverage, (and another pre-existing condition limitation period), students should make sure coverage is in place and paid for when taking a term off from school, even if the student is leaving the country. Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from this Policy to group coverage provided under another plan.**

#### MEDICAL EXPENSE BENEFITS

Each Insured Student has a Major Medical Benefit maximum per Accident or Sickness of \$50,000. In no event will the benefit maximum for all Accidents and Sickness exceed \$50,000 in any consecutive 12-month period for each Insured Individual.

Each Eligible Dependent has a Major Medical Benefit maximum per Accident or Sickness of \$25,000. In no event will the benefit maximum for all Accidents and Sickness exceed \$25,000 in any consecutive 12-month period for each Insured Individual.

#### Copayments and Coinsurance

A Copayment will be applied to Covered Expenses as follows:

1. For charges of a Physician, Covered Expenses will be paid at:
  - a. 80% without application of a Copayment for services provided to an Insured Student at a Student Health Center.
  - b. 80% after the Insured Individual pays a \$25 Copayment per visit for services provided by a Participating Provider.
  - c. 60% after the Insured Individual pays a \$25 Copayment per visit for services provided by a Physician who is not a Participating Provider.
2. For charges incurred at a Hospital (including inpatient and outpatient services), Covered Expenses will be paid at:
  - a. 80% after the Insured Individual pays a \$100 Copayment per admission for services provided by a Participating Provider.
  - b. 60% after the Insured Individual pays a \$100 Copayment per admission for services provided by a Hospital which is not a Participating Provider.
3. For charges incurred at a Hospital for emergency room care:
  - a. 80% after the Insured Individual pays a \$100\*\* Copayment per visit for services provided by a Participating Provider.
  - b. 60%\* after the Insured Individual pays a \$100\*\* Copayment per visit for services provided by a Hospital which is not a Participating Provider.

\* If it was not reasonably possible to get to a Participating Provider Hospital for Emergency Care, the Participating Provider level of payment will be payable.

\*\* This Copayment will not apply if the emergency room Physician recommends Hospital confinement and the Insured Individual is so confined in the Hospital immediately after the visit.

Benefits will be paid at the levels described above unless stated otherwise.

"Emergency Care" means covered services required to screen and stabilize an Insured Individual within 48 hours after an accidental Injury or Emergency Medical Condition. Such condition is one that is sudden, unexpected and manifests itself by symptoms of sufficient severity to lead a prudent lay person to believe immediate medical care is required. Such conditions may include those placing the patient's health in jeopardy; impairment of bodily functions; dysfunction of any bodily organ or part; uncontrolled pain; or pregnancy complications.

#### Out-of-Pocket Expense Maximum

When \$3,000 in Out-of-Pocket Expenses has been paid by an Insured Individual during a calendar year, the level of benefit payments, if otherwise applicable, will automatically increase to 100% for additional Covered Expenses incurred by that Insured Individual during the remainder of that calendar year, and Copayment charges will no longer apply. An Out-of-Pocket Expense is the share of any otherwise Covered Expense and Copayment amounts which an Insured Individual pays.

#### Medical Benefits

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable as stated above for a Covered Expense if: (1) the Copayment requirement is met; (2) the expense is incurred due to a covered Injury or Bodily Infirmary; and (3) the Insured Individual has not exceeded the Major Medical Benefit maximum for the Accident or Sickness for which the expense is incurred, or for all Accidents or Sickness in any consecutive 12 month period. Covered Expenses under the Policy are limited to the following types of expenses prescribed by a Physician for therapeutic treatment of covered Injury or Bodily Infirmary when the fees for such are Reasonable and Customary:

1. Charges for diagnosis and treatment by a Physician.
2. Charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges.
3. Charges by a Hospital for medical care received on an outpatient basis and outpatient medical supplies used on the premises of a Hospital.
4. Charges for laboratory, x-ray, and other diagnostic examinations.
5. Charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay 100% of charges for such drugs used on an inpatient basis or dispensed by a Physician at a Student Health Center and 50% of charges for such drugs not dispensed by a Physician at a Student Health Center and used for outpatient treatment.
6. Charges for emergency professional ambulance service by ground or air to a Hospital up to a maximum benefit of \$500 (see Medical Evacuation Benefit for air service to an Insured Individual's home country).
7. Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
  - a. man-made limbs or eyes for the replacing of natural limbs or eyes.
  - b. casts, splints or crutches.
  - c. purchase of a truss or brace.
  - d. oxygen and rental of equipment for giving oxygen.
  - e. rental of a wheelchair or hospital bed.
  - f. rental of dialysis equipment and supplies.
  - g. colostomy bags and ureterostomy bags.
  - h. two external post-operative breast prostheses.

The policy will not cover rental charges for equipment in excess of the purchase price of the equipment.

Coverage for prosthetic devices will be provided as required by Colorado law. Prosthetic device means an artificial device to replace, in whole or in part, an arm or leg. Benefits for prosthetic arms and legs are limited to the most appropriate model that adequately meets the medical needs of the Insured Individual as determined by a Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.
8. Charges for home health care performed by a licensed home health agency when prescribed by a Physician in lieu of Hospital services, provided the Hospital services would have been Covered Expenses.
9. Charges for one routine baseline or screening mammogram in any consecutive 12 month period for women age 18 and over, or more frequently based on a Physician's recommendation.
10. Charges for services and supplies required for the treatment of diabetes and diabetes self-management education programs, including medical nutrition therapy.
11. charges for the cost of cervical cancer vaccines for all females for whom a vaccination is recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services.

### **Pregnancy Expenses**

Covered Expenses for pregnancy are payable on the same basis as Covered Expenses for any other Bodily Infirmity. Coverage includes prenatal care and counseling, normal pregnancy, postnatal care and counseling, and complications of pregnancy.

“Complications of pregnancy” is defined as follows:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar conditions of comparable severity. This does not include false labor, occasional spotting, physician-prescribed bed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy but not creating a distinct complication of pregnancy.
- Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Pregnancy coverage also includes post-delivery inpatient Hospital care for a mother and her newly born Child in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists which is 48 hours following a vaginal delivery, or 96 hours following a caesarean section; except if the 48 or 96 hours end after 8 P.M., coverage will continue until 8 A.M. the following morning. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

### **Newborn Infants**

A newborn Child of an Insured Student will automatically be an Insured Individual for 31 days from the moment of birth **only** for Covered Expenses incurred which are due directly to Injury or Bodily Infirmity, premature birth, or a congenital condition which exists at birth. If coverage of a newborn Child beyond the initial 31 days will result in an increase in premium, in order to continue the coverage (1) notice of the birth of the Child must be provided to the Company within 31 days from the date of the birth; and (2) the required payment of the appropriate premium, must be received by the Company. If (1) and (2) above are not satisfied, coverage of a newborn Child, including any Continuation of Benefits, will terminate 31 days from the date of birth.

### **Post-Mastectomy Coverage**

Coverage of a Medically Necessary mastectomy will also include coverage of the following:

1. physical complications during any stage of the mastectomy, including lymphedemas;
2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

### **Mental Health Conditions**

Charges for inpatient and outpatient treatment of mental health conditions (*other than Biologically-Based Mental Illness and Mental Disorders and Mental Disorders, as defined in this policy*) are payable as follows:

#### **Inpatient treatment:**

- up to 45 days in any one 12-month benefit period while confined in a Hospital; or
- up to 90 days for partial hospitalization in any one 12-month benefit period.

Partial hospitalization means treatment must be continuous for at least 3 but less than 12 hours in any 24-hour period. Two days of partial hospitalization will count as one day of inpatient confinement. Each day of inpatient care will reduce by two days the 90 days available for partial hospitalization care.

#### **Outpatient treatment:**

up to 20 visits per 12-month benefit period for outpatient treatment in a Hospital. Medically necessary services may be provided by a registered professional nurse, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist, when acting within the scope of his/her license, or under the direct supervision of a Doctor or a licensed psychologist.

As used in this provision, the term “Hospital” includes a psychiatric hospital or, for outpatient treatment only, a community mental health center or mental health clinic which meets all requirements set by state law. Autism is not considered to be a mental health condition.

### **Biologically Based Mental Illness**

Covered Expenses for biologically-based mental illness, as defined below, are payable on the same basis as Covered Expenses for any other bodily infirmity. Biologically-based mental illness means:

1. schizophrenia;
2. schizo-affective disorder;
3. bipolar affective disorder;
4. major depressive disorder;
5. specific obsessive-compulsive disorder; and
6. panic disorder.

If Benefits are paid under this provision for any Covered Expense, payment for that same expense will not be duplicated under any other Plan provision.

### **Mental Disorders**

Covered Expenses for mental disorders, as defined below, are payable on the same basis as Covered Expenses for any other bodily infirmity. Mental Disorders means:

1. posttraumatic stress disorder;
2. drug and alcohol disorders;
3. dysthymia;
4. cyclothymia;
5. social phobia;
6. agoraphobia with panic disorder;
7. general anxiety disorder, and
8. anorexia nervosa and bulimia nervosa (to the extent those diagnoses are treated on an out-patient, day treatment and in-patient basis, exclusive of residential treatment).

### **Benefits for Cleft lip or palate**

Charges for medically necessary care and treatment for newborn Children with cleft lip or cleft palate or both, including:

1. oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
2. prosthetic treatment such as obturators, speech appliances, and feeding appliances;
3. orthodontic treatment;
4. prosthodontic treatment;
5. rehabilitative speech therapy;
6. otolaryngology treatment; and
7. audiological assessments and treatment.

### **Inherited Enzymatic Disorder Benefit**

Charges for the Medically Necessary treatment of inherited enzymatic disorders including medically necessary medical foods for home use when prescribed by a physician, are payable on the same basis as any Bodily Infirmity.

This disorder includes, but is not limited to: phenylketonuria (PKU), maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia.

Benefits are payable for newborns with a diagnosis of PKU up to 21 years of age; except that the maximum age for PKU Benefits for women who are of Child-bearing age is thirty-five (35) years of age. Coverage for other inherited enzymatic disorders may not be limited by age.

### **Early Intervention Services**

This policy covers early intervention services for eligible children from birth to the child's third birthday, when services are provided by a qualified early intervention service provider, and when the child has been identified as eligible for services under Part C of the Individuals with Disabilities Act. The IDEA defines an infant or toddler with a disability to mean an individual under three years of age who needs early intervention services because the child

- is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the areas of cognitive development, physical development, communication development, social or emotional development and adaptive development; or
- has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.

Coverage will be limited to a \$5,725 calendar year maximum per child, and is not subject to deductible or copayment. Coverage for early intervention services will not be applied to any other policy maximum, including a lifetime maximum.

Early intervention services means services as defined by the Colorado Department of Human Services in accordance with Part C of the IDEA, that are authorized through an eligible child's Individualized Family Service Plan (IFSP). Coverage does not include non-emergency medical transportation, respite care, service coordination as defined in 34 CFR 303.12(d)(11) and assistive technology.

### **Child Health Supervision Services**

Charges for child health supervision services are payable for a Dependent child from birth to age 13. The services to be covered at each visit include, but are not limited to:

- A history;
- Physical exam;
- Growth and developmental assessment;
- Anticipatory guidance and education;
- Immunizations and laboratory tests; and
- Safety and health education counseling.

Coverage for immunizations, appropriate to the age of the child and in keeping with prevailing medical standards, will be based on the recommended immunization schedule from the following sources:

- Advisory Committee on Immunization Practices, [www.cdc.gov/nip/acip](http://www.cdc.gov/nip/acip);
- American Academy of Pediatrics, [www.aap.org](http://www.aap.org); and
- American Academy of Family Physicians, [www.aafp.org](http://www.aafp.org).

Coverage for services will be limited to:

- Five visits and one PKU test from birth through twelve months;
- Two visits from thirteen through thirty-five months;
- Three visits from three through six years of age; and
- Three visits from seven through twelve years of age.

Coverage will be limited to one visit payable to one provider for all the services provided at each visit.

### **Congenital Defects and Birth Abnormalities**

The policy covers medically necessary physical, occupational and speech therapy for a covered child from the child's third birthday to the child's sixth birthday in connection with the care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes up to 20 visits per year for each therapy, whether the purpose of the therapy is to maintain to improve functional capacity.

### **Telemedicine**

Charges for medical services rendered through the use of telemedicine for residents of Colorado counties with a population of 150,000 or less will be payable on the same basis as for any face-to-face consultation. Telemedicine benefits are not covered when a participating provider is within the Insured Individual's geographic area. Telemedicine benefits include coverage for diagnosis, consultation, treatment, transfer of medical data or education related to health care services. Such health care services are delivered by the use of interactive audio, interactive video, or interactive data communication. Coverage does not include consultations with a provider via telephone or facsimile.

### **Prostate Cancer Screening**

Benefits will be paid for routine prostate-specific antigen (PSA) blood test and digital rectal examination payable at 100% without application of deductible, co-insurance, or per visit fee subject to a \$65.00 calendar year maximum for:

- a. men over the age of 50; or
- b. men over the age of 40 who are in high risk categories.

### **General Anesthesia Related to Dental Procedures**

General anesthesia and associated facility charges are covered for dental procedures when determined to be Medically Necessary, or for a dependent child who:

- has a physical, mental or medically compromising condition; or
- has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
- is extremely uncooperative, unmanageable, anxious, or uncommunicative and who has dental needs deemed sufficiently important that dental care cannot be deferred; or
- has sustained extensive orofacial and dental trauma.

### **Physiotherapy Expenses**

Covered Expenses for Physiotherapy (as defined below) which are incurred while not confined in a Hospital and which are billed by a Physician or physiotherapist shall not exceed the maximum amounts shown below. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

"Physiotherapy" means treatment of Injury or Bodily Infirmity by the use of physical means including, but not limited to, air, heat, light, water, electricity, massage, manipulation, acupuncture or active exercise.

The maximum Physiotherapy benefit is \$500 in any consecutive 12 month period. The maximum benefit per visit after satisfaction of the Copayment is \$50 for the first visit and \$25 thereafter.

### **Medical Evacuation Benefit**

Subject to prior approval from the Company or its authorized administrator, as an additional benefit the policy will cover, up to a maximum benefit of \$50,000, charges for air evacuation of an injured or sick Insured Individual and a Health Care Provider or Escort, if directed by the attending Physician, to the individual's home country or country of regular domicile, provided air evacuation:

- (1) is upon the attending Physician's written certification; and
- (2) results from a covered Injury or Bodily Infirmity.

### **Repatriation Benefit**

Subject to prior approval from the Company or its authorized administrator, as an additional benefit, the policy will cover up to a maximum benefit of \$25,000 in the aggregate, reasonable expenses which are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence in the individual's home country. This benefit does not include transportation expenses of any person accompanying the body. Prior approval from the Company or its authorized administrator is required.

### **Continuation Benefits**

Covered expenses incurred, while Hospital confined, will be payable up to a maximum benefit of \$5,000 or 13 weeks, whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's insurance terminates. Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

### **Coordination of Benefits**

If the Insured Individual has other group type, governmental, or automobile no fault medical benefits coverage, the benefits payable under this policy will be coordinated with the other coverage so that the combined benefits paid or provided by all plans will not exceed 100% of the allowable expense. One plan will be determined to be primary under policy rules and its benefits will be payable first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

## **EXCEPTIONS AND EXCLUSIONS**

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the types of Covered Expenses or identified in the policy as an additional benefit.
2. for medical care, treatment, supplies or services for the Insured Individual in his/her home country or country of regular domicile.
3. for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, abortion (except spontaneous and non-elective abortion), circumcision, learning disabilities, immunization, obesity, allergy tests, vitamins, and antitoxins.
4. for routine physical or health examinations.
5. for any care in connection with the teeth, gums, jaw (except due to Injury resulting from an Accident), or structures directly supporting the teeth, myofascial pain, or temporomandibular joint dysfunction, except the policy will cover Injury to natural teeth resulting from an Accident, up to a maximum benefit of \$100 per tooth and an overall maximum of \$500 per Accident.
6. in excess of the Reasonable and Customary charge.
7. for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from: (a) an Injury; (b) a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or (c) a mastectomy (refer to the Post Mastectomy Coverage provision).
8. for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy.
9. for hearing aids, eyeglasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery.
10. for Injury or Bodily Infirmity if covered to any extent under any occupational benefit plan, Workers Compensation or similar law or medical payments under individual automobile insurance (except no-fault).
11. for birth control, including surgical procedures and devices.
12. for Injury arising out of practice for or participation in professional sports.
13. for medical care, treatment, supplies or services for Accidents arising out of practice for or participation in interscholastic or intercollegiate sports.
14. for medical care, treatment, services, and supplies for which no charge is made or for which no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider.
15. for intentionally self-inflicted Injury or Bodily Infirmity, suicide, or attempted suicide, while sane; or Injury or Bodily Infirmity resulting from taking part in the commission of an assault or felony.
16. for diagnosis, treatment and all other care related to infertility.
17. TENS (Transcutaneous Electrical Nerve Stimulation) units.
18. for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline.

19. resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license.
20. for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, terrorism, participation in the military service of any country, or participation in a riot or civil disorder.
21. for medical care, treatment, services, or supplies normally given without charge and provided by employees or Physicians employed by, under contract with, or retained by the Policyholder.
22. for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.

**Pre-Existing Condition Limitations**

The policy will not cover charges or expenses due to a pre-existing Injury or Bodily Infirmary or complication thereof. A pre-existing Injury or Bodily Infirmary is one where the Insured Individual has consulted a Physician; had medicine prescribed; or is receiving or has received medical care for that Injury or Bodily Infirmary in the 6 months prior to the Insured Individual's Effective Date of Coverage under the Policy. Pregnancy is not a pre-existing condition.

However, after an Insured Individual's insurance has been in force for 12 consecutive months, Covered Expenses incurred after this 12 month period for a pre-existing Injury or Bodily Infirmary will be payable. Pregnancy is not a pre-existing condition.

**Modifications to Pre-Existing Limitations:** Pre-existing limitations will not be imposed on an Eligible Student or Eligible Dependent who enrolls for coverage as a Federally Eligible Individual. If an Eligible Student has a dependent that does not meet the Federally Eligible Individual definition, the Eligible Dependent will be subject to the pre-existing limitations as defined in the Policy.

The Policy will not impose pre-existing limitations on a Child who was covered by Creditable Coverage within 31 days of birth, adoption or Placement for Adoption, provided the Child has not subsequently been without Creditable Coverage for more than 90 days.

"Creditable Coverage" means any of the following coverage, obtained in the United States, that an Insured Individual had prior to enrollment under the Policy: an employee group health plan; health insurance coverage, a student health plan, individual or group, including coverage through a Health Maintenance Organization (HMO); Medicare; Medicaid; TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families; a medical care program of the Indian Health Service or of a tribal organization; a state health risk pool; a health plan offered under the Federal Employee Health Benefits Program; a public health plan established or maintained by a political subdivision of a state to provide insurance coverage; a health benefit plan established by the Peace Corps Act; or a State Children's Health Insurance Program (S-CHIP). Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan. Coverage provided by this Policy is not considered Creditable Coverage by this or other student health policies.

Days of Creditable Coverage that occur before a Significant Break in Coverage do not count towards satisfaction of the pre-existing limitation. A Significant Break in Coverage means a period of 63 days during all of which the individual does not have Creditable Coverage.

"Federally Eligible Individual" means an individual who meets all of the following: the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under this Policy; the individual's most recent prior Creditable Coverage was under an insurance plan offered in connection with an employee group health plan, governmental plan or church plan; the individual is not eligible for coverage under a group health plan, Medicare or Medicaid; the individual does not have other health insurance coverage; the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

**DEFINITIONS**

"**Accident**" means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual and independent of any other such force or event.

"**Average Semiprivate Charge**" means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

"**Bodily Infirmary**" means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual

"**Copayment**" means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion.

"**Doctor or Physician**" means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a close relative of the Insured Individual, or residing at the same legal residence as the Insured Individual. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Medical Benefits are provided under the Policy.

"**Hospital**" means an institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

"**Hospital Admission**" means a single period of hospital confinement or outpatient care for one or more causes.

"**Injury**" means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual.

"**Medical Condition**" means any bodily or mental disease, illness or injury requiring treatment by a Physician.

"**Medically Necessary**" means health care services and supplies (such as medication) that a Doctor, exercising prudent clinical judgment, provides to an Insured Individual for the purpose of preventing, evaluating, diagnosing or treating a Medical Condition or its symptoms, and are:

- a. in accordance with generally accepted standards of medical practice; and
- b. clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Insured Individual's Medical Condition; and
- c. not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Policy; and
- d. specifically allowed by the licensing statutes which apply to the Doctor who provides the service or supply; and
- e. at least as medically effective as any standard care and treatment; and
- f. not primarily for the convenience, psychological support, education or vocational training of the Insured Individual, Doctor or other health care provider; and
- g. not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured Individual's Medical Condition.

For these purposes, "generally accepted standards of medical practice" means the:

- a. standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- b. recommendations of an American Medical Association-recognized Doctor specialty society;
- c. prevalent practices of Doctors in the relevant clinical area; or
- d. any other relevant factors.

The Company may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined by the Company, in accordance with the definition above.

"**Mental Health Condition**" means neurosis, psychoneurosis, psychosis, or mental disease or disorder of any kind resulting from any cause including, but in no way limited to, biological cause.

"**Participating Provider**" means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates.

**“Placed For Adoption”** means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of adoption. Placement is considered terminated upon termination of legal obligation.

**“Reasonable and Customary”** means, with regard to charges for medical services or supplies, the lowest of:

- a. the usual charge by the provider for the same or similar medical services or supplies;
- b. the usual charges of most providers of similar training and experience in the same or similar geographic ‘area’ for the same or similar service or supplies; or
- c. the actual charge for the services or supplies.

‘Area’ means the location where the medical care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of medical care or supplies.

**“Sickness”** means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of One Period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. “One Period” commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.

**“Student Health Center”** means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits. ‘Student Health Center’ also includes a designated Take Care Health Center or other similar facility specified by the educational institution if such institution does not have a designated Student Health Center.

#### **CLAIMS PROCEDURE**

Written notice of any event that may lead to a claim under the policy must be given to the Company or its authorized administrator within 60 days after the event.

Written proof of loss must be furnished to the Company within 90 days after the date of loss. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

#### **IMPORTANT NOTICE**

This brochure is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the Master Policy, the Master Policy will govern.

Any provision of the Master Policy in conflict with the laws of the jurisdiction in which the Policyholder is located is hereby automatically amended to conform to the minimum requirement of those laws.

The Policyholder requires its international and practical training students to carry medical insurance coverage. This coverage must be accepted by the student unless proof of other coverage (acceptable to the Company) is provided.

For information and assistance,  
call the Lewer Agency at 1-800-821-7710.

**Insured By:**  
**Great-West Life & Annuity Insurance Company**