

# 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, exclusively for  
**Avila University**

- 100% coverage after Copayment for most expenses
- Medical evacuation benefit
- Repatriation benefits
- Coverage complies with Title IX
- Prompt claims & administrative service

*Available Exclusively Through:*

**The Lewer Agency, Inc.**  
*Student Insurance Plans*

P. O. 32247  
Kansas City, Missouri 64171-5247  
Phone 1/800-821-7710 Fax 1/816-960-7064  
www.lewermark.com

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

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### ELIGIBILITY

The LewerMark International Students 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 a student of the Policyholder who is engaged full-time in international or practical training educational activities, is temporarily outside the student's home country or country of regular domicile as a non-resident alien in the United States; and has a current passport or applicable student visa.

An "Eligible Dependent" means a dependent of an Eligible Student who has a current passport or visa; is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien in the United States; is the Eligible Student's lawful spouse or unmarried Child (natural Child, step-Child, adopted Child or Child Placed For Adoption under age 19 and dependent upon the Eligible Student or the student's spouse for the Child's main support and care); resides with the Eligible Student; and is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible. Dependent children born in the United States and disabled, unmarried children age 19 and over (exceptions apply) are also Eligible Dependents.

"Child" means an Eligible Student's natural Child; step-Child; adopted Child or a Child Placed For Adoption which means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of the adoption of such Child. Coverage is from the date of birth if a petition for adoption is filed within 30 days of birth of such Child or from the date of placement if a petition for adoption is filed within 30 days of placement of such Child. The Child's placement with the Eligible Student is considered terminated upon the termination of such legal obligation.

### COVERAGE PERIOD

Provided an Enrollment is properly completed and the correct premium is received timely, an Eligible Student or Eligible Dependent becomes an Insured Individual on the first day of the school term for which coverage is applied for or, if different, the effective date required by the Policyholder for all similarly situated eligible persons. Dependent coverage cannot become effective prior to the effective date of coverage of the Eligible Student.

Coverage will automatically terminate on the earliest of:

- A. The date the Policy terminates;
- B. The last day of the period for which premium has been timely paid according to Policy provisions;
- C. The date the Insured Individual is no longer eligible for coverage;
- D. 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;
- E. 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 qualified plan.**

### MEDICAL EXPENSE BENEFITS

Each Insured Student has a Major Medical Benefit maximum of \$100,000 per Accident or Sickness, but not exceeding \$100,000 for all Accidents and Sickness in any consecutive 12 month period.

Each Insured Dependent has a Major Medical Benefit maximum of \$50,000 per Accident or Sickness, but not exceeding \$50,000 for all Accidents and Sickness in any consecutive 12 month period.

### *Copayments and Coinsurance*

A Copayment will be applied to Covered Expenses as follows:

1. For charges from a Physician, Covered Expenses will be paid at:
  - a. 100% without application of a Copayment for services provided to an Insured Student at a Student Health Center or at a TakeCare Health System office;
  - b. 100% after the Insured Individual pays a \$15 Copayment per visit for services provided by a Participating Provider;

- c.. 80% after the Insured Individual pays a \$15 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:
- 100% after the Insured Individual pays a \$50 Copayment per admission for services provided by a Participating Provider; The Copayment for a visit to the Emergency Room is \$100.
  - 80%\* after the Insured Individual pays a \$50 Copayment per admission for services provided by a Hospital which is not a Participating Provider. The Copayment for a visit to the Emergency Room is \$100.
- \* 100% if for Emergency Care, provided by a Non-Participating Provider Hospital, if it was not reasonably possible to get to a Participating Provider Hospital for emergency care. The Copayment for a visit to the Emergency Room is \$100.

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 80% 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 20% 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 Infirmity; 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 Infirmity when the fees for such are Reasonable and Customary:

- Charges for diagnosis and treatment by a Physician or registered nurse (not a close relative of or same legal residence as the Insured Individual);
- Charges for daily Hospital room and board not exceeding the Hospital’s Average Semiprivate Charge and Intensive Care Unit charges;
- Charges by a Hospital for medical care received on an out-patient basis and outpatient medical supplies used on the premises of a Hospital;
- Charges for laboratory, x-ray, and other diagnostic examinations;
- 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;
- 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);
- Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
  - man-made limbs or eyes for the replacing of natural limbs or eyes;
  - casts, splints or crutches;
  - purchase of a truss or brace;
  - oxygen and rental of equipment for giving oxygen;
  - rental of a wheelchair or hospital bed;
  - rental of dialysis equipment and supplies;
  - colostomy bags and ureterostomy bags; and
  - two external post-operative breast prostheses.

- The policy will not cover rental charges for equipment in excess of the purchase price of the equipment;
- 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;
  - Charges for one routine baseline or screening mammogram and one routine pap smear in any consecutive 12 month period for women age 18 and over, or more frequently based on a Physician’s recommendation;
  - Charges for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.
  - Charges for nutritional formulas for the therapeutic treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids;
  - charges for the following childhood immunizations from birth to age 5 without application of the Copayment: poliomyelitis; rubella; rubeola; mumps; diphtheria; pertussis; tetanus; hepatitis B (HBV); Hemophilus influenzae type B (Hib); and varicella (chickenpox);
  - Annual prostate exam (DRE) and prostate-specific antigen (PSA) test for men age 50 and over and for any man who is at risk because of race (African-American) or family history;
  - Annual colorectal cancer exam, fecal occult blood test and either: a DRE and flexible sigmoidoscopy every 5 years; or a DRE and colonoscopy every 10 years; or a DRE and double contrast barium enema every 5 years, for those age 50 and over and anyone at risk because of family history; and
  - charges for prescription oral contraceptives and devices dispensed by a Student Health Center or a licensed pharmacist, payable at 50%. Drugs or devices intended to induce an abortion are excluded.

**Pregnancy Benefits**

Covered Expenses for pregnancy are payable the same as any other Covered Expenses for any other Bodily Infirmity with respect to an Insured Student or Covered Dependent spouse. No benefits are payable for any expense which relates to the pregnancy of a dependent Child.

Pregnancy Expenses shall include coverage of “Complications of Pregnancy” which relate to the pregnancy of an Eligible Dependent Child. “Complications of Pregnancy” means conditions distinct from pregnancy but adversely affected by, or caused by pregnancy, such as postpartum hemorrhage, toxemia, hyperemesis gravidarum, rupture or prolapse of the uterus, caesarean section, ectopic pregnancy which is terminated, spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible and similar medical and surgical conditions of comparable severity, but shall not include elective abortion, false labor, occasional spotting, physician prescribed rest, morning sickness, and similar conditions associated with the management of a difficult pregnancy.

Pregnancy coverage shall also include a minimum of 48 hours of inpatient Hospital care following a vaginal delivery and a minimum of 96 hours of inpatient Hospital care following a caesarean section, for the mother and her newly born Child. However, if the attending Physician to the mother or newborn determines that the 48 or 96 hour stay is not Medically Necessary, and the mother agrees, the Policy will pay benefits for post-discharge care in lieu of the minimum inpatient Hospital confinement. Covered post-delivery care includes two visits, at least one of which will be in the home, by a R.N. with experience in maternal and Child health nursing or a Physician.

Covered services will include, but not be limited to:

- physical assessment of the newborn and mother;
- parent education;
- assistance and training in breast or bottle feeding;
- education and services for complete childhood immunizations; and
- the performance of any necessary and appropriate clinical tests.

**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.

#### ***Newborn Infants***

A newborn Child of an Insured Student is eligible for coverage from the date of birth provided that (1) notice of the birth is provided to the Company or its authorized administrator within 31-days from the date of birth; and (2) premium for coverage from the date of birth is received. If (1) and (2) above are not satisfied, a newborn Child of an Insured Individual will automatically be an Insured Individual only for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. This coverage, including any continuation of benefits, will terminate 31 days after the date of birth.

If notification of the birth of a Child is provided within the 31 day period, the Insured Student will be allowed the greater of the remaining 31 day period or 10 days following the receipt of enrollment forms to enroll for dependent coverage. If the Insured Student enrolls and makes the required retroactive contributions, coverage on the Child will continue.

#### ***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.

#### ***Intercollegiate/Interscholastic Sports Benefit***

Benefits will be payable up to a maximum benefit of \$5,000 per Accident arising out of practice for or participation in intercollegiate or interscholastic sports.

#### ***Anesthesia/Dental Care Coverage***

Covered Expenses incurred for dental care for the giving of general anesthesia including a Dentist's Hospital or office charges for treatment requiring general anesthesia are payable on the same basis as Covered Expenses for any other Bodily Infirmary; provided such covered expenses were incurred by a Child under the age of 5 years, a severely disabled person, or a person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

#### ***Second Opinion (Cancer)***

A newly diagnosed cancer patient has the right to a referral from the attending Physician to a board-certified Specialist in the specific cancer diagnosis area prior to treatment. Benefits for a second opinion will be paid on the same basis as for any other Specialist referral. Any further treatment by the Specialist is subject to the Policy's terms and conditions.

#### ***Clinical Trials (Cancer)***

Benefits will be paid for Medically Necessary health care services provided to an Insured Individual in a phase III or IV clinical trial for the prevention, early detection or treatment of cancer that meets the following criteria:

1. the treating facility and personnel must have the expertise and training to provide the treatment;
2. there must be at least two non-investigational alternatives;
3. available clinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives;
4. must be approved or funded by one of the following entities:
  - a. one of the National Institutes of Health (NIH);
  - b. NIH Cooperative Group or Center;
  - c. the Food and Drug Administration in the form of an Investigational new drug application;
  - d. the U. S. Department of Defense;
  - e. the U. S. Department of Veterans' Affairs;
  - f. an institutional review board in Missouri that has approval from the Department of Health and Human Services pertaining to the protection of human subjects; and
  - g. a qualified research entity meeting the criteria for support grant eligibility from a NIH Center.

Coverage will be on the same basis as for similar services and includes services needed to administer the drug or device under evaluation and all medical items and services that are generally provided in a clinical trial except:

1. the item under investigation;
2. items and services used for data collection and analysis that are not used in the direct treatment of the patient; and
3. items provided free of charge to the participants.

#### ***Conditions and Maximums for Treatment of Mental Illness and Chemical Dependency***

Medical care benefits for the evaluation and treatment of Mental Illness and Chemical Dependency include Covered Expenses for Medically Necessary services rendered or billed by a Hospital, a Doctor and a residential or non-residential facility. Benefits are payable on the same basis as any Sickness with the following exceptions for the treatment of Chemical Dependency:

1. Coverage while confined in a Hospital is limited to 30 days in any calendar year with a lifetime maximum of 120 days. A day of inpatient treatment may be exchanged for two outpatient visits.
2. Coverage for psychiatric/psychological services performed in a licensed facility or by a Doctor while not so confined is limited to 20 visits in any consecutive 12 month period with a lifetime maximum of 80 visits. If outpatient benefits are exhausted while inpatient days remain available, inpatient days will be exchanged, one day for two visits, in order to continue benefits.

"Mental Illness" means any of the following conditions or diagnosis: schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, Chemical Dependency, autism and other disorders of infancy, childhood and adolescence and all other diagnoses as presented in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders as published by the American Psychiatric Association, **including such disorders which are biologically or organically based or due to biochemical imbalances.**

"Chemical Dependency" means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

#### ***Continuation Benefits***

If an Insured Individual's Major Medical Benefits ends after having been continuously insured under this Policy (and under any group plan or policy providing similar medical or health care benefits which it replaces) for the entire three month period prior to his/her date of termination, coverage may be continued, subject to rules as outlined in the Policy. Contact the Policyholder or the Lower Agency to determine if you are eligible for Continuation Benefits.

A spouse whose Major Medical Benefits ends due to divorce shall have the same continuation rights.

If Student status is reinstated during the continuation period, then coverage under the Group Policy will be reinstated for the Student and any dependents that were covered under continuation.

Benefits payable under this provision will terminate if an Insured Individual becomes covered for the Injury or Sickness, for which Benefits were continued, under any other medical coverage.

#### ***Extended Major Medical Benefits on Termination of Insurance***

If an Insured Individual is disabled when the Policy terminates, benefits will still be payable for the Injury or Sickness causing the disability, provided all of the following conditions are met:

1. the medical care, services or supplies are given or received within 12 months after this Major Medical Benefit ends;
2. an Insured Individual remains disabled from the same Injury or Sickness until care is received;
3. an Insured Individual does not become covered under similar group type coverage or plan for such Injury or Sickness; and
4. an Insured Individual continues to meet all the requirements of eligibility except the requirement for full-time educational activities or dependency.

#### ***Coordination of Benefits***

If the Insured Individual has other 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. A plan is primary when: the plan does not have a COB provision; the plan designates itself as an 'excess' or 'always secondary' plan; or if both plans have a COB provision, under the rules it is determined to be primary. When both plans have a COB provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. Principal Insured Individual - The plan that covers the person as a Principal Insured Individual is primary. If an Insured Individual is also covered by Medicare, the plan covering the person as a Principal Insured Individual is primary, the plan covering the person as a dependent of a Principal Insured Individual is secondary, and then Medicare.

2. Dependent children -

a. If the parents are not separated or divorced, the plan that covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan that covered the parent longer is primary. If the other plan does not have the 'birthday rule', the rule in the other plan will determine the primary plan.

b. If the parents are separated or divorced, the plan which covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; and finally the plan which covers the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan that covers the parent is primary.

If the decree names the parent other than the natural parent with custody, the Company must be notified and have actual knowledge of those terms.

Any Benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and the third, respectively.

If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Continuation coverage - Continuation coverage provided under either federal or state law is secondary. If the other plan does not have this rule, this rule is ignored.

4. Length of coverage - If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

This Policy coordinates benefits with the following coverage: (1) group or blanket plans on an insured basis; (2) other plans which cover people as a group; (3) a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union; (4) a pre-payment plan which provides medical, vision, dental or health services; (5) government plans, except Medicaid; (6) group auto insurance, but only to the extent medical benefits are payable under group auto insurance (7) no-fault auto insurance on an individual basis, except where not allowed by the state in which this plan is issued; (8) single or family subscribed plans issued under a group or blanket type plan.

#### **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 Infirmary.

#### **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.

#### **EXCEPTIONS AND EXCLUSIONS**

The Policy will not cover charges or expenses:

- for medical care, treatment, supplies, or services not listed in the types of Covered Expenses or identified in the policy as an additional benefit;
- for medical care, treatment, supplies or services for the Insured Individual in his/her home country or country of regular domicile;
- 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, (except for covered childhood immunizations), obesity, allergy tests, vitamins, and antitoxins;

- for routine physical or health examinations, except if listed as a Covered Expense under the Medical Benefits section;
- for any care in connection with the teeth, gums, jaw (except due to Injury resulting from an Accident), or structures directly supporting the teeth, myofacial 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;
- in excess of the Reasonable and Customary charge;
- 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);
- for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
- 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;
- for Injury or Bodily Infirmary 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);
- for birth control surgical procedures;
- for Injury arising out of practice for or participation in professional sports;
- 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;
- for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony;
- for diagnosis, treatment and all other care related to infertility;
- 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;
- resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license in the state where the Insured Individual primarily resides while attending school;
- for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
- 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; and
- 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.

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.

**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 who 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 62 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, 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; 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.

#### **Prescription Discount Card**

The prescription discount card is offered through Express Scripts, and provides a discount on many prescription drugs. The discount program provides discounts at participating nationwide.

The list of drugs included on the discount plan generally matches the type of drugs covered by the LewerMark inbound programs. Participating pharmacies can be located by visiting Express Scripts website: [www.member.express-scripts.com](http://www.member.express-scripts.com) and creating a member account using the ID number located on the insured’s Express Scripts ID Card. You can also get pharmacy information by contacting Express Scripts at 1-800-451-6245.

The discount card does not guarantee that a prescription will be covered. For prescription reimbursements, please complete a claim form and mail to the Lewer Agency for reimbursement. Mail completed form to:

The Lewer Agency, Inc.  
P.O. Box 32247  
Kansas City, MO 64171-5247

#### **24/7 Medical Help Line**

This service provides the student with 24 hour telephone access to registered nurses. The nurses can provide the student with easy to understand information on a wide range of health issues. The toll free phone number is 800-769-1259. Multilingual providers are available on the Medical Help Line 24 hours a day, 7 days a week.

#### **Global Emergency Medical Evacuation – Assist America**

In the event that a student becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transportation necessary to evacuate a participant student to the nearest facility capable of providing appropriate care. With one phone call, Assist America’s team of professionals will handle the transportation arrangements to a more suitable hospital.

Assist America’s medical personnel will also maintain regular communication with the enrolled member’s attending physician and/or hospital and relay any information to the participant’s family.

For global emergency assistance call Assist America’s toll free number, 800-872-1414.

#### **Finding a PPO Network Provider – Great-West Healthcare**

By enrolling in this insurance program the insured member has the Great-West Healthcare Provider Network available for in-network medical services. The use of a provider in the Great-West Healthcare network may reduce the insured’s out of pocket expenses, as network providers have negotiated to accept lower fees as payment for their services.

There are many doctors and hospitals available. Go to [www.lewermark.com](http://www.lewermark.com) and click “Find a Doctor.” Select Great-West Healthcare as the PPO network.

#### **Repatriation – Assist America**

If a student requires medical assistance upon being discharged from a hospital, Assist America will repatriate him/her home or to a rehabilitation facility with a medical or non-medical escort, as necessary. In the event of death of a member participant, Assist America will render every possible assistance in returning the mortal remains including locating a funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. An Assist America card will be supplied to the student once the student has enrolled in the LewerMark Health Insurance Plan.

The Assist America card must be carried at all times. For global emergency assistance or when the insured student is 100 miles away from his/her primary residence a toll-free number is available, 800-872-1414.

#### **HIPAA**

HIPAA Privacy: The Lewer Agency, Inc. and Great-West Life and Annuity Insurance Company value your privacy and have in place policies to protect your private health information. To view both of our HIPAA Privacy Policies, please see our website at [www.LewerMark.com](http://www.LewerMark.com). To obtain a copy of either of these policies, please contact The Lewer Agency, Inc., Privacy Officer, 4534 Wornall Road, Kansas City, Missouri, 64111, (816) 753-4390 or (800) 821-7715.

#### **DEFINITIONS**

“**Accident**” means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a sudden onset to that Insured Individual and independent of any other 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

“**Hospital**” means only such a place which is lawfully operated and licensed as a hospital for the care and treatment of sick or injured individuals; has permanent and full-time care for bed patients; has a staff of one or more licensed physicians available at all times; provides 24-hour a day care by registered nurses on duty or call; has surgical facilities; and is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a hospital used as such. Hospital also means a free standing surgical center which: is a licensed public or private place; has an organized medical staff of Physicians; has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; and has RN services in the facility.

“**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 sudden onset to that Insured Individual.

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

“**Medically Necessary**” means only care and treatment the Company determines meets all of the following conditions: (1) the care and treatment is appropriate given the symptoms and is consistent with the diagnosis, if any; (2) it is rendered in accordance with generally accepted medical practice and professionally recognized standards; (3) it is not treatment that is generally regarded as experimental or unproven; and (4) it is specifically allowed by the licensing statutes which apply to the provider who renders the service. “Appropriate” means the type, level, and length of service and setting needed to provide safe and adequate care and treatment.

**“Mental or Nervous Disorder”** 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.

**“Physician or Doctor”** 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.

**“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.

**“Specialist”** means any Doctor who is not a family physician, general practitioner, internist, pediatrician or OB/GYN.

#### **GRIEVANCE PROCEDURE**

An Insured Individual, his/her representative or his/her Doctor may submit a written Grievance to the Company

Grievances pertaining to an unfavorable claim decision will be acknowledged by the Company, in writing, within ten working days of receipt. An investigation will be conducted within 20 working days of receipt of the Grievance (except if the life or health of an Insured Individual is in serious jeopardy\*). If the Company is unable to complete the investigation within such time, the Insured Individual will be notified in writing on or before the 20<sup>th</sup> working day:

1. that the investigation has not been completed;
2. but will be completed within an additional 30 working days; and
3. the reasons for which the additional time is needed.

Within five working days after the investigation is completed, a representative of the Company not involved in the original circumstances giving rise to such Grievance or in the resulting investigation will resolve such Grievance and notify the Insured Individual of the Company’s decision in writing. If the Grievance was submitted on the Insured Individual’s behalf by his/her Doctor or representative, a separate notice will be sent to him/her within 15 working days of the completion of the investigation.

Should the Insured Individual, his/her representative or his/her Doctor decide to appeal the Company’s decision, a panel review may be requested. The panel consists of other persons enrolled in health benefit plans insured by the Company and the Company’s representatives who were not involved in the original circumstances giving rise to the Grievance or in any resulting investigation or decision.

The review will be conducted within 20 working days of receipt of the appeal (except if the life or health of an Insured Individual is in serious jeopardy\*). If the panel is unable to complete the review within such time, the Insured Individual will be notified in writing on or before the 20<sup>th</sup> working day:

1. that the review has not been completed;
2. but will be completed within an additional 30 working days; and
3. the reasons for which the additional time is needed.

Within five working days after the review is completed, the panel will reach a decision and the Company will notify the Insured Individual of its decision in writing. If the review was requested on the Insured Individual’s behalf by his/her Doctor or representative, a

separate notice will be sent to him/her within 15 working days of the completion of the review.

\* If the life or health of an Insured Individual is in serious jeopardy or the Insured Individual’s ability to regain maximum function is jeopardized, a complaint or a resulting appeal may be phoned in by the Insured Individual or his/her representative or Doctor. The Company will return the call within 72 hours and provide written confirmation of the Company’s decision within 3 working days of the determination.

In addition to the Insured Individual’s right to appeal a claim as described above, the he/she has a right to contact the Missouri Insurance Department at:

Harry S. Truman State Office Building  
301 West High Street  
Jefferson City, Missouri 65101  
1-800-726-7390

Grievance means a written complaint submitted by or on behalf of an Insured Individual regarding:

1. the availability, delivery or quality of health care services;
2. claim payment; or
3. the administration of the Policy’s terms and conditions.]

#### **CLAIM PROCEDURES**

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. The Company will then send the claimant forms for filing proof of claim. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of claim requirements by giving the Company a statement in writing of the nature and extent of the loss within the time required.

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. If it was not reasonably possible to give notice and proof in writing in the time required, the Company shall not reduce or deny the claim for this reason if proof is filed as soon as reasonably possible.

Payment of claims will be made as soon as the Company receives satisfactory proof of loss. All benefits will be paid to the Insured Student, unless a valid written assignment of benefits has been executed.

If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.

#### **Legal Actions**

No action at law or in equity may be brought to recover on the Policy before the end of 60 days and after proof in writing of the loss has been given. No action may be brought after 3 years from the time written proof of loss is required.

#### **Physical Examinations and Autopsy**

The Company, at its own expense, has the right to examine the person with respect to whom benefits are claimed while the claim is pending. It may also have an autopsy performed, at the Company’s expense, unless prohibited by law.

#### **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**