

LEWERMARK

medical benefits plan for international students

*C*OVERAGE FOR INTERNATIONAL STUDENTS THAT EVERYONE CAN UNDERSTAND



Making a World of Difference

Benefits for Accident and Sickness for the
University of Arkansas at Little Rock

- 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

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.

An "Eligible Student" means any international and practical training student of the Policyholder who meets 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).

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.

An "Eligible Dependent" means a dependent of an Eligible Student who has a current passport and visa (non-domiciled United States citizen – passport only); 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; 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. When a petition for adoption of a Child is filed by the Insured Individual, dependent coverage for that Child will begin on the date of the filing if such individual applies for coverage within 60 days of the date of the filing. For a newborn adopted Child, dependent coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the Child.

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 covered under the International Policy has a Major Medical Benefit maximum per Accident or Sickness of \$100,000. In no event will the benefit maximum for all Accidents and Sickness exceed \$100,000 in any consecutive 12-month period for each Insured Student.

Each Eligible Dependent covered under the International Policy 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 Dependent.

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. 90% without application of a Copayment for services provided to an Insured Student at a Student Health Center;
 - b. 90% after the Insured Individual pays a \$25 Copayment per visit for services provided by a Participating Provider;
 - c. 70% 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. 90% after the Insured Individual pays a \$100 Copayment per admission for services provided by a Participating Provider;
 - b. 70% 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. 90% after the Insured Individual pays a \$100** Copayment per visit for services provided by a Participating Provider;
 - b. 70%* 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 expense is incurred due to a covered Injury or Bodily Infirmary; and (2) 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 up to 100% of charges for such drugs used on an inpatient basis or dispensed by a Student Health Center and 50% of charges for such drugs not dispensed by a Student Health Center Physician and which are 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 prescription contraceptive drugs and devices. Prescription contraceptive drugs will be covered on the same basis as other covered prescription drugs.
8. 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.
9. 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.
10. 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.
11. Charges for one pap smear in any consecutive 12 month period for women age 18 and over, or more frequently based on a Physician's recommendation.
12. Charges for colorectal cancer screening examinations and laboratory tests for an Insured Individual:
 - a. who is 50 years of age or older;
 - b. who is less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society guidelines;
 - c. regardless of age, if the person is experiencing symptoms of colon cancer.
13. Charges for anesthesia and facility charges in connection with dental procedures performed in a Hospital for an Insured Person who is:

- a. under 7 years of age, if 2 Dentists certify that the Child has a significantly complex dental condition; or
- b. any age, with a serious medical or physical condition; or
- c. any age, if a Physician determines that the person has a significant behavioral problem.

This does not include coverage of the dental procedure.

- 14. Charges for treatment of loss or impairment of speech or hearing, when performed by a licensed speech pathologist or audiologist. This does not include coverage of hearing instruments or devices. The maximum Benefit is \$500 in any consecutive 12-month period. The maximum benefit per visit after satisfaction of the applicable Copayment is \$50 for the first visit and \$25 thereafter. Charges in excess of these maximums shall not be included as Covered Expenses under the Policy.

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 Infirmary 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.

Pregnancy Benefits

Covered Expenses for pregnancy are payable the same as any other Covered Expenses for any other Bodily Infirmary 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 coverage also includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYNs.

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 90 days from the date of birth; and (2) premium for coverage from the date of birth is received. As an additional benefit, if (1) and (2) above are satisfied, the newborn Child will be covered for Hospital room and board (or nursery) charges, routine Physician hospital visits, and circumcision. Such Covered Expenses for Well Baby Care are payable until the earlier of the date the Mother is discharged from the Hospital or the date the Child is 5 days old. 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 90 days after the date of birth.

Child Health Supervision Services

Coverage will be provided to dependent Children for “Child Health Supervision Services” from birth through 18 years of age at the following intervals:

20 visits will be included at approximately the following age intervals:

	birth	3	years
2	weeks	4	years

2 months	5 years
4 months	6 years
6 months	8 years
9 months	10 years
12 months	12 years
15 months	14 years
18 months	16 years
2 years	18 years

"Child Health Supervision Services" means the periodic review of a Child's physical and emotional health provided by or under the supervision of a single Physician, during the course of one visit, including medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests, all in keeping with prevailing medical standards.

Coverage for immunization services is not subject to deductibles, coinsurance and Benefit Maximums. All other children's preventive health care services are subject to the same deductibles, coinsurance and Benefit maximums as other similar coverage in the Plan.

In Vitro Fertilization

Coverage will be provided for in vitro fertilization subject to the following conditions:

1. The insured female's oocytes must be fertilized with the sperm of her spouse;
2. The Insured Student and his/her spouse have had a history of unexplained infertility of at least 2 years; or the infertility is associated with one or more of the following medical conditions:
 - i. Endometriosis;
 - ii. Exposure in utero to Diethylstilbestrol (DES);
 - iii. Blockage or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - iv. Abnormal male factors contributing to the infertility; and
3. The insured female has been unable to obtain successful pregnancy through a less costly infertility treatment covered by this policy.

The in vitro fertilization procedures must be performed at a medical facility licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in Arkansas or no such licensing program is operational, then coverage will be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Cyropreservation (the procedure whereby embryos are frozen for later implantation) is an eligible expense within these in vitro fertilization benefits.

A pre-existing condition limitation of 12 months applies for these in vitro fertilization Benefits.

This in vitro fertilization Benefit is subject to a lifetime maximum of \$15,000.

Inherited Metabolic Diseases

Benefits for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas for use in the treatment of phenylketonuria (PKU) will be considered a Covered Expense provided:

1. such food products are prescribed as medically necessary for the therapeutic treatment of PKU; and

2. the products are administered under the direction of a physician; and
3. the cost of such products exceeds \$2,400 per year.

Benefits are subject to deductibles, coinsurance, copayments and maximums on the same basis as other similar Benefits under the Plan.

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 and Nervous Disorders/Substance Abuse

Benefits will be paid for inpatient treatment of a Mental or Nervous Disorder or Substance Abuse up to an aggregate limit of 10 days of inpatient care in any consecutive 12 month period. Outpatient treatment will be paid subject to a maximum number of 3 outpatient visits in any consecutive 12 month period.

Intercollegiate/Interscholastic Sports Benefit

Benefits will be payable up to a maximum benefit of \$15,000 per Accident arising out of practice for or participation in intercollegiate or interscholastic sports.

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. 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 (except as covered under the Newborn Infants provision), 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, 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.
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 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).
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, 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.
14. for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony.
15. for diagnosis, treatment and all other care related to infertility; except as provided in the Covered Expenses section under the In Vitro Fertilization benefit Provision.
16. TENS (Transcutaneous Electrical Nerve Stimulation) units.
17. 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.
18. resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license.

19. 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.
20. 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.
21. 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 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; 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 one of the following types of plans or 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 unforeseen force or event 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

“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 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 also means such place operated mainly to treat a Mental or Nervous Disorder if it meets the standards below:

- a. is a Hospital, psychiatric Hospital or outpatient psychiatric center licensed by the Arkansas Health Department; or
- b. is a Community Mental Health Center certified by the Arkansas Department of Human Services, Division of Mental Health Services.

“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 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.

“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.

Prescription & Vision Discount Card

The prescription and vision discount cards are offered through Express Scripts, and provides a discount on many prescription drugs and eye care products. The discount program provides discounts at participating pharmacies and vision providers 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 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

Participating vision providers can be located by visiting the Cole Managed Vision website: www.colemanagedvision.com/find or by calling at 1-800-804-4384 for Vision Plan #56003. Simply present the Express Scripts Prescription Drug Identification card and the student will automatically receive the discounted prices. There is no claim to file and no waiting for reimbursement.

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 800-872-1414. 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.

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.

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 and click "Find a Doctor." Select Great-West Healthcare as the PPO network.

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. 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.

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 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