2023-2024 Plan Brochure

Portland Community College

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Program Managed and Administered by:

The Lewer Agency, Inc. *(the "Program Manager")*
9900 W. 109th St., Suite 200 | Overland Park, KS 66210 | 1(800) 821-7710

Underwritten by:

Crum & Forster SPC *(the "Company")* **for and on behalf of ITI SP**

Notice
Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this summary of coverage. This plan contains both insurance and non-insurance benefits. Complete provisions pertaining to the insurance portion of the plan are contained in the policy. In the event of any conflict between this summary of coverage and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of your plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to your school. For a detailed plan description, exclusions, and limitations please view the plan on file with your school.

Note: This insurance is not subject to and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens to obtain PPACA-compliant insurance coverage. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster SPC.

Privacy Statement
We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at (800) 821-7710.

Policy Number: LM-8675309-776

IMPORTANT CONTACT INFORMATION

LEWERMARK CLIENT ADVOCACY TEAM

For questions regarding benefits or claims status, contact:

- Toll Free: **1 (800) 821-7710** (Monday–Friday, 8:00 a.m. to 5:00 p.m. Central Time)
- Chat with us at: www.lewermark.com
- Email us at: lewermarksupport@lewer.com
- Your school webpage: www.lewermark.com/portlandcc
- The Lewer Agency, Inc. | Student Insurance | 9900 W 109th St. Suite 200 | Overland Park, KS

TELADOC*

Teladoc is a convenient and affordable option that allows students to talk to a doctor who can diagnose, recommend treatment, and prescribe medication, when appropriate, for many of their medical issues.

- Download: FREE **TELADOC** app from your device's app store today
- Web: www.teladoc.com
- Toll Free: **1 (800) 835-2362**
- 24/7/365 access

TELUS Health Student Support by TELUS Health* (formerly My SSP by LifeWorks)

TELUS Health Student Support is an International Student Support Program designed to help international students face the challenges of balancing school, adjusting to a new culture, and adapting to their other responsibilities.

- Download: FREE app from your device's app store today
- Web: myssp.app
- Toll Free: **1 (866) 743-7732**
- Phone: **001-416-380-6578** (If calling outside of North America)
- Available 24/7

TOGETHERALL*

The Togetherall Online Community is designed to provide a safe and anonymous place for students to get online peer support. Registered mental health practitioners are on hand 24/7 to keep the community safe.

- Web: https://account.v2.togetherall.com/register/student
- Available 24/7

SCHOLASTIC EMERGENCY SERVICES*

Students, staff or parents should contact Scholastic Emergency Services if there is a life-threatening emergency or illness.

- Toll Free: **1 (877) 488-9833** (Toll free inside the USA)
- Phone: **1 (609) 452-8570** (If calling outside of the USA)

PPO NETWORK*

To locate doctors and facilities within the Aetna network, visit:

- Web: Find an Aetna Provider

**These services are not insurance and are not affiliated with Crum & Forster, SPC*

TELADOC*

Quality Care + Convenience

Teladoc provides your students with 24/7/365 access to U.S. board-certified doctors by phone. Teladoc is a convenient and affordable option that allows students to talk to a doctor who can diagnose, recommend treatment, and prescribe medication, when appropriate, for many of their medical issues including:

- **Sinus problems**
- **Bronchitis**
- **Allergies**
- **Cold and flu symptoms**
- **Respiratory infection**
- **Ear infection**
- **And more!**

Download the TELADOC App!

www.teladoc.com

GET IT ON Google Play | Download on the App Store

Contact TELADOC 24/7/365

Call toll-free: 1(800) 835-2362

TELUS Health Student Support*

Tailored Support for International Students

This student assistance program is designed to support you in your native language and cultural context to help you resolve mental and physical health concerns, cultural shock, adaptation to life in the U.S., and much more. International students can call or chat for mental health counseling 24/7 with no limit.

Help is available from a network of qualified professionals for no additional charge.

TELUS Health's International Student Support Advisors can help anytime, anywhere with:

- Adapting to new cultures
- Being successful at school
- Relationships with friends and family
- Stress, sadness, loneliness, and more

Students can connect with an Advisor who:

- Speaks their language
- Understands their culture
- Keeps their information confidential
- Is available 24/7 and at no cost to the student

Contact TELUS Health 24/7

Toll Free: 1 (866) 743 – 7732

Calling Outside U.S.: 001-416-380-6578

Download the App!

myssp.app

GET IT ON Google Play | Download on the App Store

**These services are not insurance and are not affiliated with Crum & Forster, SPC*

TOGETHERALL*

Online Community Support

Togetherall is a safe, online community to share feelings anonymously and get support to improve mental health and well-being. In the community people support each other, safely monitored by licensed and registered mental health practitioners.

Register with Togetherall today!

https://account.v2.togetherall.com/register/student

SCHOLASTIC EMERGENCY SERVICES (SES)*

Service Arrangements for Emergency Situations

Students, staff and/or parents should contact Scholastic Emergency Services if there is a life- threatening emergency or illness. Scholastic Emergency Services is a service-arranger, not insurance, so please contact them first as they cannot reimburse for any services you pay for or use. **SES will not pay for services on a reimbursement basis**, so you must contact them immediately.

If you call 911 for a medical emergency, your next phone call should be to Scholastic Emergency Services.

They will make all arrangements for you to provide for the following:

- Assistance finding a provider
- Translation assistance
- Medical evacuation transportation
- Critical care monitoring
- Compassionate family visit
- Medical trauma counseling
- Prescription assistance
- Emergency message transmission
- Repatriation (return of mortal remains)
- Legal assistance

IMPORTANT: You must call SES prior to using any of the above services

CONTACT SES 24/7

1 (877) 488-9833 (Toll free inside the USA)

1 (609) 452-8570 (If calling outside the USA)

Reference Number: **01-AA-LEW-05034**

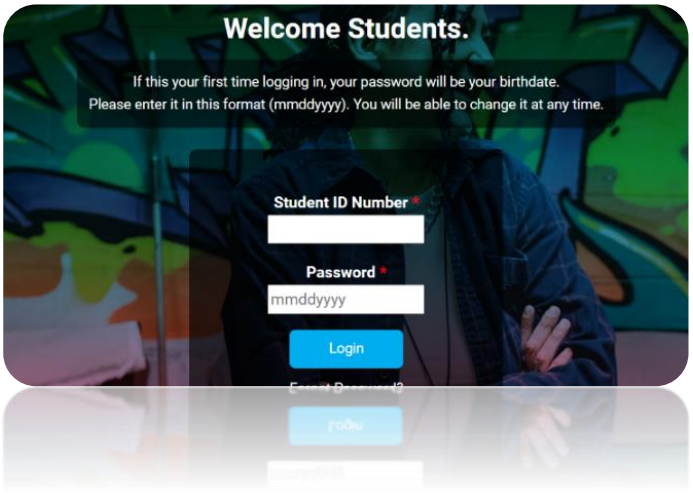
**These services are not insurance and are not affiliated with Crum & Forster, SPC*

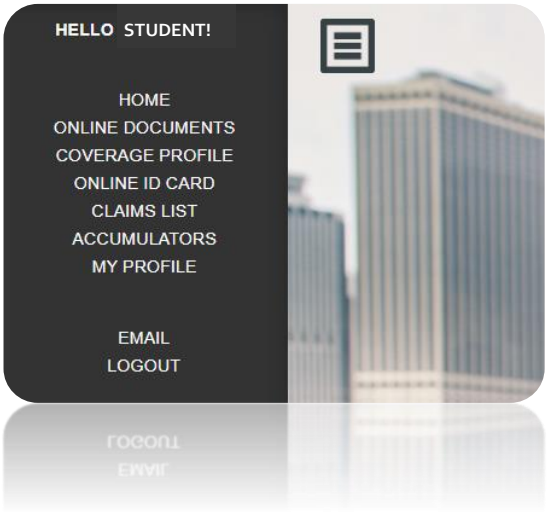
LOGGING INTO YOUR STUDENT ACCOUNT

Go to www.lewermark.com and click the button, "**Student Login**" on the upper right.

Type your student ID number in the space. There must be 9 digits, so if your ID is shorter than 9 numbers, add zeros to the beginning of your ID. *For example, 001234567.* If your ID has a letter, replace it with a zero.

Your default password is your date of birth in order of month, day, then year. *For example, November 3, 2003, would be 11032003.*



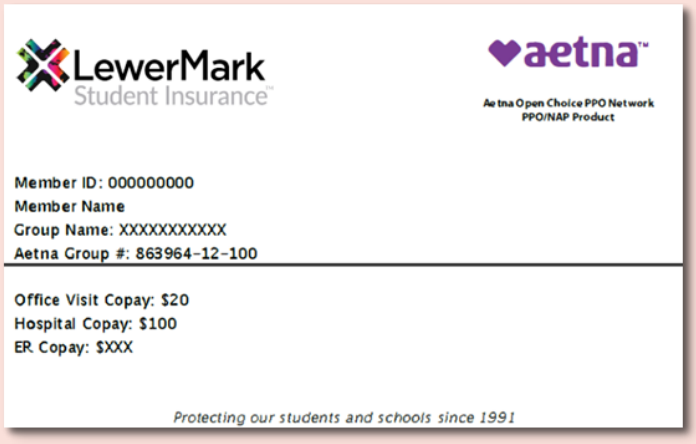


The next screen will prompt you to change your password and add a security question. **Do not skip this step.** When you log back into your account you will use your new, unique password.

On your account page, click the menu icon and a list appears. Click "**ONLINE ID CARD**" to bring up your insurance ID card.
You can choose to download your card or print it.

We recommend keeping a copy on your phone, so you always have it with you! You will use your card when you go to a doctor or pharmacy. ***Tip****: Tell them you have "Aetna" insurance, not LewerMark.*

Front of the ID card



Back of the ID card

If you have problems logging into your account or getting your ID card, contact our Client Advocacy Team by the chat feature, calling 1 (800) 821-7710, or emailing us at lewermarksupport@lewer.com.

HOW TO FIND A DOCTOR

To find an in-network provider you can go to LewerMark's home page at www.lewermark.com.

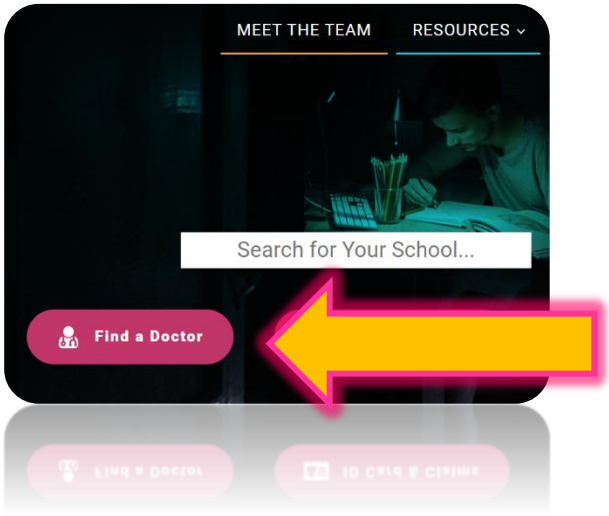
Click the "**Find a Doctor**" button.

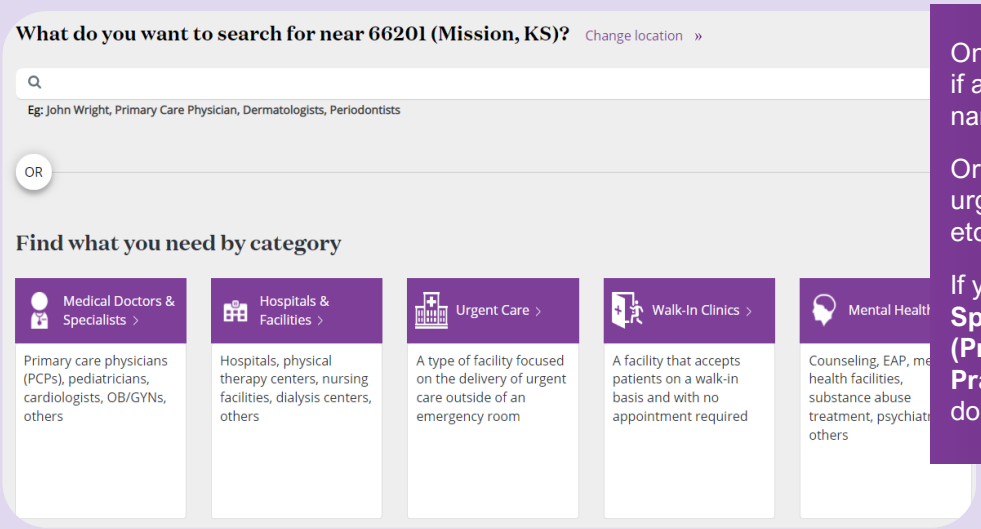
Click on "**Find an AETNA Provider**."

Put in your zip code in the space that reads,

"**Enter location here**."

Select "**Passport to Healthcare Primary PPO Network**." If you don't get many options, come back to this screen, and select "Secondary PPO Network."





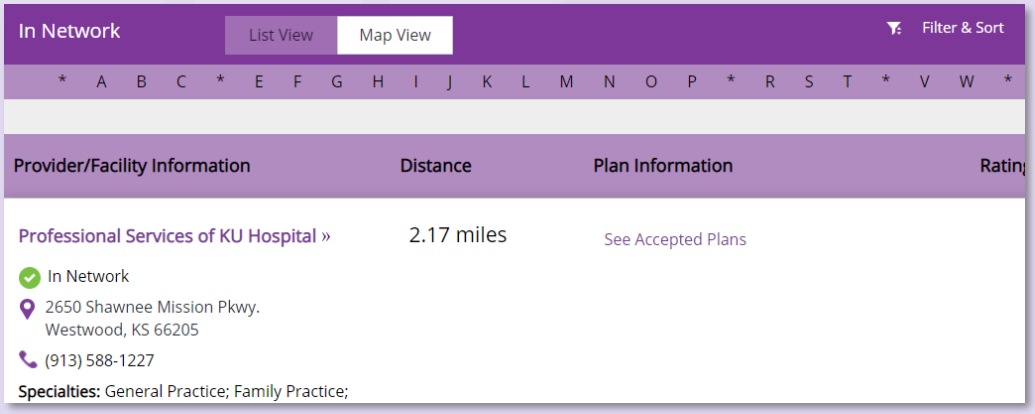
Once you get to this screen, you can see if a doctor is in-network by typing their name next to the magnifying glass.

Or you can look for general doctors, urgent cares, walk-in clinics, counselors, etc. in your area.

If you select "**Medical Doctors & Specialists**" and then "**Doctors (Primary Care)**" and then "**General Practice**," you will receive a list of doctors in-network.

***Tip**: Call ahead to make sure the doctor is currently in-network with Aetna and to see if they are taking new patients.*

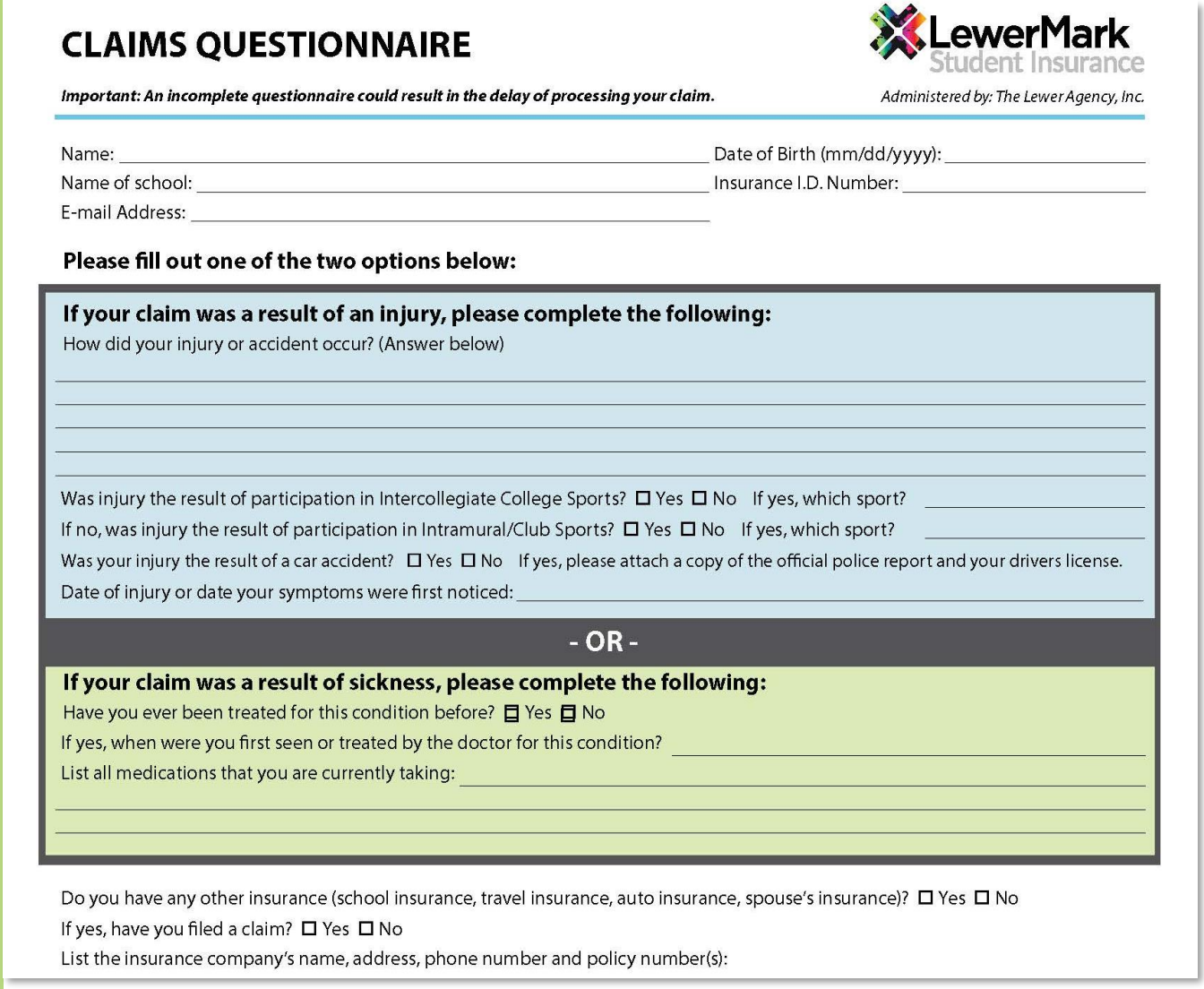
***Tip**: You can filter your search. For example, you can filter by gender or by the language a doctor speaks.*



If you need help finding a doctor or hospital, contact our Client Advocacy Team by the chat feature, calling 1 (800) 821-7710, or emailing us at lewermarksupport@lewer.com.

WHAT IS A CLAIMS QUESTIONNAIRE?

You may receive a questionnaire in the mail after you visit the doctor or go the hospital. This is called a *Claims Questionnaire*. We use the information you provide on the Claims Questionnaire to help process your claim. A sample questionnaire is shown below:



CLAIMS QUESTIONNAIRE

LewerMark Student Insurance

Important: An incomplete questionnaire could result in the delay of processing your claim.

Administered by: The Lewer Agency, Inc.

Name: _____ Date of Birth (mm/dd/yyyy): _____

Name of school: _____ Insurance I.D. Number: _____

E-mail Address: _____

Please fill out one of the two options below:

If your claim was a result of an injury, please complete the following:

How did your injury or accident occur? (Answer below)

_____

_____

_____

_____

_____

Was injury the result of participation in Intercollegiate College Sports? ☐ Yes ☐ No If yes, which sport? _____

If no, was injury the result of participation in Intramural/Club Sports? ☐ Yes ☐ No If yes, which sport? _____

Was your injury the result of a car accident? ☐ Yes ☐ No If yes, please attach a copy of the official police report and your drivers license.

Date of injury or date your symptoms were first noticed: _____

- OR -

If your claim was a result of sickness, please complete the following:

Have you ever been treated for this condition before? ☐ Yes ☐ No

If yes, when were you first seen or treated by the doctor for this condition? _____

List all medications that you are currently taking: _____

_____

_____

Do you have any other insurance (school insurance, travel insurance, auto insurance, spouse's insurance)? ☐ Yes ☐ No

If yes, have you filed a claim? ☐ Yes ☐ No

List the insurance company's name, address, phone number and policy number(s):

To fill out a full Claims Questionnaire, please go to: www.lewermark.com/claim-forms and send it to our Client Advocacy Team at lewermarksupport@lewer.com.

Notice and Proof of Claim - Timely Filing Requirement

Written proof of loss must be given to the Program Manager within 90 days after the date of loss or as soon as thereafter as reasonably possible. Notice should include the name of the Covered Student, the Participating School's identifying number, and the Covered Student's contact information, including address, email address, and any other necessary information that may be reasonably required. If services are rendered on consecutive days, such as for hospital confinement, the date of loss will be considered the last date of service. The Program Manager would not deny nor reduce any claim if it were not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Program Manager within one one-year after the date of service. If a claim was timely filed originally, but the plan's Program Manager requested additional documentation, the healthcare provider has up to one year to submit the requested information.

This document is intended to be read in its entirety. To understand all the conditions, exclusions, and limitations applicable to the Policy's benefits, please read all Policy provisions carefully. Only those benefits elected by each Participating School and shown on its Schedule of Benefits will apply to its enrolled Eligible Students.

The Company appointed the Program Manager to administer the Policy on its behalf. References to the Program Manager throughout the Policy include the Company where appropriate. Any notice delivered to the Program Manager shall be considered received by the Company.

Eligible Student

Eligible Student means a registered and enrolled student of a Participating School who:

1. is a legal resident of a country other than the United States, its territories, or possessions;
2. is enrolled and actively engaged in Full-Time Studies;
3. has not been granted permanent residency status in the United States, its territories, or possessions; and
4. holds and continually maintains an F-1, J-1, M-1, Q-1 or other approved category of student visa or immigration status.

United States citizens and residents are not eligible for coverage.

A Plan Participant is no longer enrolled and actively engaged in Full-Time Studies upon graduation; a Plan Participant and their Covered Dependents, if any, become ineligible for coverage under the Policy upon the Plan Participant's graduation. However, the Plan Participant may be entitled to up to 60 days of continued coverage after graduation if one of the following exceptions apply:

1. The Plan Participant is transferring to another educational institution;
2. The Plan Participant is approved for OPT and, on that basis, qualifies for continued coverage under the terms of the Policy document; or
3. The Plan Participant qualifies for Extended Coverage because they have graduated, are returning to their Home Country, and applied for Extended Coverage as required by the Policy.

A person may not be covered as a Dependent and a Covered Person at the same time.

Visiting Faculty and Scholars

This section applies exclusively to individuals holding an Exchange Visitor non-immigrant visa, otherwise referred to as a J1 visa.

J1 visa holders who possess and maintain current passports and valid J1 visa status may be considered for coverage under the Policy if engaged in educational activities with the Participating Organization.

J1 visa holders will be considered Eligible Students. As an Eligible Student, J1 visa holders will have access to all Policy benefits and limits and will be subject to all exceptions and exclusions indicated herein. In addition, in compliance with Department of State requirements, insured J1 visa holders who exhaust the stated Policy Year Maximum Benefit will have access to additional J1 medical benefits of $100,000 per accident or sickness. These additional J1 medical benefits will be subject to all policy terms, internal benefit limits, exceptions, and exclusions.

Optional Practical Training

An Optional Practical Training ("OPT") student with the applicable F-1 visa may be considered eligible for coverage for no more than twelve months from the date the student is approved for OPT while they are participating in OPT work directly related to the student's major area of study. STEM OPT extension students are eligible for a maximum of twenty-four months coverage from the date the student is approved for OPT.

OPT students who fail to maintain OPT eligibility or who transition to H-1B status will no longer be eligible for coverage.

SCHEDULE OF BENEFITS (Continued)

Accident & Sickness Medical Expense Benefits

A Covered Person is free to use the provider of their choice. However, the Policy provides different levels of benefits and copays depending on where the Covered Person chooses to receive care or whether they use the services of a Participating Provider. Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

POLICY BENEFITS – PER COVERED STUDENT	
Policy Year Maximum Benefit	$500,000
Lifetime Maximum Benefit per Covered Injury or Sickness	$500,000
Annual Deductible Per Covered Person	$100
Out-of-Pocket Expense Maximum Per Covered Person	$5,000
Pre-Existing Condition Benefit – First six months of continuous coverage (Pre-Existing Pregnancy Coverage: Benefits for expenses associated with a Pregnancy conceived prior the Effective Date of Coverage will be limited to the Pre-Existing Benefit maximum)	$2,500

COPAYS	In-Network	Out-of-Network
Student Health Center or CVS Minute Clinic	$0	-
Office Visit	$20	$20
Hospital	$100	$100
Hospital Emergency Room	$100	$100

COINSURANCE	
In-Network Provider	90% of Preferred Allowance
Out-of-Network Provider	70% of Usual, Reasonable & Customary (URC) Charges

COVID-19 COVERAGE
Treatment for COVID-19 (coronavirus) is covered.
Medically necessary, diagnostic testing for the coronavirus is covered.
COVID-19 VACCINE
The COVID-19 (coronavirus) vaccine is covered up to $100 per policy year.

After a Covered Person satisfies the Policy Out-of-Pocket Expense Maximum during a single policy year, all levels of Coinsurance increase to 100% for Covered Expenses incurred during the remainder of the policy year, and Copay charges will no longer apply, except as to outpatient prescription drugs. Benefits will be paid at this level unless stated otherwise in the Covered Medical Expenses section or in the Exceptions and Exclusions section. In addition, any benefit maximums will still apply, and the Covered Person will not be reimbursed for any Copays.

This increase in Coinsurance does not apply to outpatient prescription drug expenses, even if the Covered Person satisfies the Policy Out-of-Pocket Expense Maximum. Copay and Coinsurance will continue to apply to prescription drug benefits received on an outpatient basis.

PRESCRIPTION DRUG BENEFITS	
Dispensed by a Student Health Center	100% of each 30-day supply
Dispensed by a Participating Network Pharmacy	50% of each 30-day supply
Administered while Inpatient at a Hospital, including those administered in a Hospital Emergency Room	90%
Prescription Contraceptives – Oral	100% of each 30-day supply dispensed by a Student Health Center or In-Network Provider
Prescription Contraceptives – Non-Oral (No coverage for intrauterine devices (IUDs) and birth control Implants nor the procedures related to placement and/or removal of such.)	50% dispensed at Student Health Center or an In-Network Provider
With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30-day supply, until the stated Prescription Drug Benefit Maximum, if any, has been met.	

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by the payment of accumulated Deductible, Coinsurance and Co-pays. Penalties and amounts above the Preferred Allowance or Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

NOTES:

- We do not pay benefits for the amount of Eligible Expenses You pay as Your Coinsurance or Co-pay amount.
- Eligible Expenses will be paid under the Inpatient benefits for Surgery or the Outpatient benefits for Surgery, but not both for the same or related procedure.

NETWORK PROVIDER ARRANGEMENTS

Network contracted providers and some walk-in clinics have agreed to accept special reduced reimbursement rates for treatment rendered to Covered Persons. This Policy will pay 90% of these negotiated rates for eligible services provided by these providers. The Covered Person will be responsible for all out-of-pocket expenses exceeding the benefits provided by this Policy.

Don't forget to bring your ID card when you visit the doctor or the pharmacy!

SCHEDULE OF BENEFITS (Continued)

COVERED BENEFITS	In-Network	Out-of-Network
Hospital Room and Board Benefit	90% of the Preferred Allowance	70% of the Semi-Private Room Rate
Intensive Care Unit Benefit	90% of the Preferred Allowance	70% of URC
Surgeon (In or Outpatient) Benefits	90% of the Preferred Allowance	70% of URC
Assistant Surgeon Benefit	90% of the Preferred Allowance	70% of URC
Anesthesia Benefit	90% of the Preferred Allowance	70% of URC
Preadmission Testing	90% of the Preferred Allowance	70% of URC
Diagnostic X-Ray and Lab Benefit	90% of the Preferred Allowance	70% of URC
Coronavirus Disease 2019 (COVID-19) Benefit (for Medically Necessary diagnostic testing, Medical Treatment, vaccinations, and booster)	90% of the Preferred Allowance	70% of URC
Ambulance Benefit	90% of the Preferred Allowance	90% of URC
Physician Visit Benefit – In or Outpatient	90% of the Preferred Allowance	70% of URC
Outpatient Nursing Services	90% of the Preferred Allowance	70% of URC
Radiation/Chemotherapy Benefit	90% of the Preferred Allowance	70% of URC
Intercollegiate Sports Benefit	Not Covered	Not Covered
Emergency Room Benefit	90% of the Preferred Allowance	70% of URC
Infusion Therapy Benefit	90% of the Preferred Allowance up to a maximum of $10,000 per policy year	70% of URC up to a maximum of $10,000 per policy year
Renal Dialysis/Hemodialysis Benefit	90% of the Preferred Allowance up to a maximum of $10,000 per policy year	70% of URC up to a maximum of $10,000 per policy year
Mastectomy Coverage Benefit	90% of the Preferred Allowance	70% of URC
Wellness Benefit (Maximum Benefit of $500 per policy year) (Not subject to Copay or Deductible)	100% of the Eligible Expenses	
STD Testing (with symptoms present)	90% of the Preferred Allowance	70% of URC
Maternity and Pre-Natal Care Expense Benefit (Conception must occur while covered under the Policy)	90% of the Preferred Allowance	70% of URC
Newborn Infant – Sick Baby Care (Maximum Benefit of $50,000) (Coverage limited to first 30 days of life)	90% of the Preferred Allowance	70% of URC
Newborn Infant – Well Baby Care (expenses incurred while hospitalized after birth)	Not Covered	Not Covered
Allergy Treatment Benefit (Medically Necessary treatment of allergies as diagnosed and prescribed by a Physician)	90% of the Preferred Allowance	70% of URC
Emergency Dental Benefit up to a maximum of $2,500	90% of the Preferred Allowance	70% of URC
Elective Termination of Pregnancy Benefit	Up to $1,000 per policy year	
Home Country Coverage Benefit	Up to $1,500 per policy year	

SCHEDULE OF BENEFITS (Continued)

COVERED BENEFITS	In-Network	Out-of-Network
Mental, Behavioral & Neurodevelopmental Disorder – Inpatient Expense (30 days maximum)	90% of the Preferred Allowance	70% of the Semi-Private Room Rate
Mental, Behavioral & Neurodevelopmental Disorder – Outpatient Expense (30 visits maximum)	90% of the Preferred Allowance	70% of URC
Alcohol and Drug Abuse – Inpatient Expense (30-day maximum)	90% of the Preferred Allowance	70% of URC
Alcohol and Drug Abuse – Outpatient Expense (10 visits maximum)	90% of the Preferred Allowance	70% of URC
Skilled Nursing Facility	90% of the Preferred Allowance	70% of URC
Hospice Care (14-day maximum)	90% of the Preferred Allowance	70% of URC
Miscellaneous Expense Benefit	90% of the Preferred Allowance	70% of URC
Self-Inflicted Injury Benefit (maximum of $10,000 per policy year)	90% of the Preferred Allowance	70% of URC
Inpatient Physiotherapy Benefit	90% of the Preferred Allowance	70% of URC
Outpatient Physiotherapy Benefit: Must be prescribed in writing by a Physician. Maximum of 20 visits.	90% of the Preferred Allowance	70% of URC
Durable Medical Equipment Expense Benefit: Must be prescribed in writing by a Physician	90% of the Preferred Allowance	70% of URC
Acupuncture and Chiropractic Benefit: Must be prescribed in writing by a Physician. Combined maximum of 12 outpatient visits for acupuncture and/or chiropractic care. Maximum of $50 per visit.	90% of the Preferred Allowance	70% of URC
Medical Evacuation Benefit	Up to $50,000 of Reasonable Expenses	
Repatriation Benefit	Up to $25,000 of Reasonable Expenses	
Continuation Benefit	Available up to a maximum of 13 weeks or up to a Maximum Benefit of $10,000, whichever is reached first	
Extended Coverage Benefit	Can provide additional coverage of up to 30 days to Plan Participants who are newly-enrolled students or who have completed their final terms of study.	

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

Applies only to Covered Persons; does not apply to spouses or dependents. Coverage terminates at age 65.
Principal Sum: $10,000

Time Period for Loss: Within 90 days of the Covered Accident

INSURED STUDENT'S COVERED LOSS	AD&D BENEFIT
Accidental Death	100% of the Principal Sum
Brain Death	100% of the Principal Sum
Loss of Both Hands	100% of the Principal Sum
Loss of Both Feet	100% of the Principal Sum
Loss of Entire Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand and One Foot	100% of the Principal Sum
Loss of One Hand and Entire Sight of One Eye	100% of the Principal Sum
Loss of One Foot and Entire Sight of One Eye	100% of the Principal Sum
Loss of Speech and Hearing (both ears)	100% of the Principal Sum
Quadriplegia (total Paralysis of both upper and lower limbs)	100% of the Principal Sum
Paraplegia (total Paralysis of both lower or upper limbs)	50% of the Principal Sum
Loss of One Hand	50% of the Principal Sum
Loss of One Foot	50% of the Principal Sum
Loss of Entire Sight of One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (both ears)	50% of the Principal Sum
Hemiplegia (total Paralysis of upper and lower limbs on one side of body)	50% of the Principal Sum
Uniplegia (total Paralysis of one lower or upper limb)	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum

If, within 90 days from the date of an Accident or Injury covered by the Policy, the Covered Person suffers a Covered Loss, We will pay the percentage of the Principal Sum set opposite the loss in the table above. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Maximum Benefit Amount shown in Schedule of Benefits.

Benefits are payable if such Injury occurs while the Covered Person is covered under the Policy.

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

Paralysis means loss of use, without Severance, of a limb. This loss must be determined by a Physician to be complete and not reversible

COVERED MEDICAL EXPENSES

We will pay Accident and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to Copay, Coinsurance Factors, Policy Period, Benefit Maximums and other terms or limits shown below, in the Schedule of Benefits, and in the Policy.

Accident and Sickness Medical Expense Benefits are only payable:

- for the Preferred Allowance or Usual, Reasonable and Customary Charges incurred after the Copay has been met;
- for Medically Necessary Eligible Expenses incurred by or on behalf of the Covered Person;
- for Eligible Expenses submitted within 365 days after the date of the Medical Treatment that is the basis for the expense.

No benefits will be paid for any expenses that exceed the Preferred Allowance or Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include the following expenses as further indicated in the Schedule of Benefits or elsewhere in this policy:

1. **Medical Treatment:** for diagnosis and Medical Treatment by a Physician or a Registered Nurse.
2. **Hospital Admission Expenses**.
3. **Outpatient Pre-Surgical Testing**.
4. **Nursing Services:** Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional Nurse.
5. **Skilled Nursing Facility (SNF):** For care and/or services at a Skilled Nursing Facility. The care and/or service must be directed toward the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

   A SNF confinement must take place within 14 days from a Hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. SNF care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.
6. **Hospice Care Benefit:** charges for a maximum of 14 days of:
   a. nursing care by a Registered Nurse;
   b. care provided by a licensed practical Registered Nurse, a vocational Registered Nurse, or a public health Registered Nurse who is under the direct supervision of a Registered Nurse;
   c. physiotherapy when rendered by a licensed therapist;
   d. medical supplies, including drugs and the use of medical appliances;
   e. physician's services; and
   f. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. **Miscellaneous Additional Benefits:**
   a. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
   b. Charges for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.
   c. Diabetes coverage that includes medical supplies, equipment and education for diabetes care.
8. **Hospital Room & Board Benefit:** We will pay charges for the Average Semiprivate Charge for each day of the Hospital Stay, up to the Maximum Benefit Amount shown in the Schedule of Benefits. Hospital Room and Board expenses include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service, provided, expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation. Hospital room and board expenses do not include personal services of a non-medical nature.
9. **Intensive Care Unit Benefit:** We will pay charges for each day of Intensive Care Unit confinement, up to the Maximum Benefit Amount shown in the Schedule of Benefits. This payment is in lieu of payment for Hospital room and board charges for those days and includes nursing services.

10. **Hospital Miscellaneous Expense Benefit:** We will pay for services, supplies and charges during a Hospital stay, up to the Maximum Benefit Amount shown in the Schedule of Benefits. Miscellaneous services include services and supplies such as: operating room cost; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services and supplies; and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

11. **Home Health Services Benefit:** Home health care services performed by a licensed home health care agency, which are prescribed by a Physician, and performed in lieu of Hospital services, provided such Hospital services would have been Eligible Expenses under the Policy. Physical therapy services are not home health services.

12. **Surgeon (In or Outpatient) Benefits:** We will pay charges for:

    a. A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits.
    b. A Physician, for assistant surgeon duties up to the Maximum Benefit Amount shown in the Schedule of Benefits.

13. **Pre-Admission Testing Benefit:** We will pay benefits for charges for pre admission testing.

14. **Anesthesia Benefit:** We will pay benefits for anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.

15. **Day Surgery Miscellaneous Benefit:** We will pay benefits for services and supplies related to surgery provided on an outpatient basis, such as: operating room costs; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services and supplies.

16. **Diagnostic X-Ray and Laboratory Benefit:** We will pay the benefit if the Covered Person requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per covered Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

17. **Ambulance Benefit:** When, by reason of Injury or Sickness, a Covered Person requires use of an Ambulance in an Emergency, We will pay the Covered Percentage of the Eligible Expenses up to the maximum shown in the Schedule of Benefits, if any, for transportation within the metropolitan area in which the Covered Person is located at that time the service is used. Ambulance Service means transportation by a vehicle designed, equipped and used only to transport the sick and injured from home or the scene of the Accident or Emergency to a Hospital or between Hospitals. Surface trips must be to the closest facility that can provide the covered service appropriate to the condition.

    Air Ambulance transportation is covered when Medically Necessary because of an Emergency. If the Covered Person is in a rural area, Air Ambulance Transportation to the nearest metropolitan area will be considered an Eligible Expense. Air Ambulance Transportation means air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

18. **Physician Visit Benefit:**

    - **Inpatient:** We will pay the Covered Percentage of the Eligible Expenses for Physician in-Hospital visits, other than pre- or post-operative care, up to the Maximum Benefit Amount, if any, shown in the Schedule of Benefits for Physician's Visit (Inpatient).
    - **Outpatient**: We will pay the Covered Percentage of the Eligible Expense for Physician office visits, up to the Maximum Benefit Amount, if any, shown in the Schedule of Benefits for Physician's Benefits (Outpatient).
    - **Consultant Physician:** If, by reason of a Covered Person's Injury or Sickness an attending Physician deems the services of a Consultant or Specialist necessary for the purpose of confirming or determining a diagnosis, and orders those services, We will pay the Covered Percentage of the Eligible Expenses incurred.

19. **Radiation/ Chemotherapy Therapy Expense Benefit:** We will pay the Covered Percentage of Eligible Expenses incurred by a Covered Person for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

a. the drug is ordered by a Physician for treatment of a specific type of neoplasm;
b. the drug is approved by the FDA for use in antineoplastic therapy;
c. the drug is used as part of an antineoplastic drug regimen;
d. current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
e. the Physician has obtained informed consent from the Covered Person for the treatment regimen that includes FDA approved drugs for off-label indications.

20. **Infusion Therapy Benefit:** We will pay the Covered Percentage of Eligible Expenses, up to the policy year maximum shown in the Schedule of Benefits, if any, for infusion therapy prescribed and administered by a licensed Physician.

21. **Renal Dialysis/Hemodialysis Benefit:** We will pay the Covered Percentage of Eligible Expenses, up to the policy year maximum shown in the Schedule of Benefits, if any, for Renal Dialysis/Hemodialysis prescribed and administered by a Physician.

22. **Mastectomy Benefit:** We will pay the Covered Percentage of Eligible Expenses for a Medically Necessary mastectomy which may also include coverage of the following:

a. physical complications during any stage of the mastectomy, including lymphedemas;
b. reconstruction of the breast;
c. Surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
d. two external breast prostheses.

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

23. **Emergency Room Benefit:** We will pay the Covered Percentage of Eligible Expenses if the Covered Person requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a covered Injury or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an Outpatient basis. An Emergency Room is not a clinic or Physician's office. Services including Physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

24. **Coronavirus Disease 2019 (COVID-19) Benefit:** We will pay the Covered Percentage for Medically Necessary diagnostic testing, Medical Treatment, vaccinations, and booster vaccinations related to the COVID-19 coronavirus or any variants of interest, concern, or high consequence.

25. **Self-Inflicted Injury Benefit:** We will pay the Covered Percentage of Eligible Expenses, up to the Maximum Benefit Amount shown in the Schedule of Benefits, for Medical Treatment required as the result of an intentionally self-inflicted Injury or Sickness, suicide, or attempted suicide, while sane or insane.

26. **Allergy Treatment Benefit:** We will pay the Covered Percentage of Eligible Expenses for Medically Necessary treatment of allergies, as diagnosed and prescribed by a Physician.

27. **Wellness Benefit:** We will pay for any combination of the following, up to the Wellness Benefit maximum shown in the Schedule of Benefits: routine physical examination or examination for participation in sport; gynecologic health screenings; routine baseline or screening mammograms; prostate and/or colorectal examinations and related laboratory tests; annual health checkups; immunization antibody testing; immunizations indicated on the Recommended Immunization Schedule by the Centers for Disease Control and Prevention; COVID-19 coronavirus diagnostic testing which is not Medically Necessary; and tuberculosis tests.

28. **Maternity and Pre-Natal Care Benefit:** We will pay the Covered Percentage of Eligible Expenses for Pregnancy coverage, including prenatal visits, two ultrasounds per pregnancy (unless more are Medically Necessary), and post-delivery inpatient Hospital care for a mother in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which is 48 hours following a vaginal delivery or 96 hours following a caesarean section. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

To be eligible for Maternity and Pre-Natal Care Benefits, conception must have occurred following the Effective Date of the Covered Person's coverage and the Covered Person's coverage cannot have terminated for any reason. If the Covered Person is eligible for Maternity and Pre-natal Care Benefits, benefits will be payable on the same basis as Eligible Expenses for any other covered Sickness. Global billing of Maternity and Prenatal Care will not be accepted without an accompanying flow chart.

This Policy does not provide coverage for midwives; services provided by birth doulas, companions, or birth supporters who assist a woman before, during and/or after childbirth; planned childbirth deliveries at home; childbirth deliveries at birthing centers; or the purchase or rental of a breast pump, even if prescribed by a Physician

29. **Newborn Infants – Sick Baby Care:** A newborn child of a Covered Person will automatically be entitled to coverage as if a covered Dependent for up to 30 days from the moment of birth only for Eligible Expenses incurred which are due directly to an Injury or Sickness which exists at birth, up to a Maximum Benefit of $50,000.

    A newborn child of a Covered Person is not a Covered Person.

30. **Pre-Existing Pregnancy Benefit:** Any expense associated with a Pregnancy conceived prior to the Covered Person's Effective Date of Coverage will be limited to the "Preexisting Condition Benefit" coverage maximum shown in the Schedule of Benefits, if any, even if the child is born after the waiting period.

31. **Elective Termination of Pregnancy Benefit:** We will pay Eligible Expenses, up to the policy year maximum shown in the Schedule of Benefits, related to the procedure for an elective termination of pregnancy. If the Covered Person experiences complications from the procedure, the Eligible Expenses will be assessed the same as any other Medical Treatment.

32. **Emergency Dental Expense Benefit:** We will pay the Covered Percentage of Eligible Expenses, up to the maximum benefit shown in the Schedule of Benefits, for charges related to Medical Treatment of Natural Teeth damaged as result of an Injury. This benefit does not cover damage to previously decayed teeth caused by chewing or biting. Only expenses for emergency dental treatment to Natural Teeth will be reimbursed.

33. **Home Country Coverage Benefit:** We will pay benefits as described in the Schedule of Benefits for Eligible Expenses incurred in the Covered Person's Home Country related to an Injury or Sickness which occurred, was diagnosed, and treated outside the Covered Person's Home Country during the period of coverage, provided that the Covered Person remains on the Participating Organization's I-20, for a maximum of 90 days on an approved vacation term.

34. **Physiotherapy Benefit:** We will pay Preferred Allowance or Usual, Reasonable and Customary expenses for eligible physiotherapy expenses incurred by the Covered Person, as described in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, if any, as to Eligible Expenses during the Claim Determination Period.

    To be eligible for coverage, physiotherapy charges must be:

    a. for treatment of a specific Injury or Sickness or following hospitalization;
    b. administered by a licensed physiotherapist as an Outpatient; and
    c. Received pursuant to a Physician referral.

    Physiotherapy charges may include treatment, such as diathermy, ultrasonic, whirlpool, heat treatments, microtherm, or any form of Physical Therapy, and office visits connected with such treatment. Physiotherapy expenses do not include massage therapy services unless performed by a licensed physical therapist or chiropractor who is operating within the scope of their license.

35. **Durable Medical Equipment:** If, by reason of Injury or Sickness, a Covered Person requires the use of Durable Medical Equipment (DME), We will pay the Covered Percentage of Eligible Expenses incurred by a Covered Person for purchase or rental of such Medically Necessary DME. In no event will we pay rental charges exceeding the purchase price of a piece of DME. Any rental charges paid will be applied toward the purchase price if the DME is purchased at a later date.

    We do not pay for replacement of Durable Medical Equipment.

    Durable Medical Equipment means medical equipment that:

a. is prescribed by a Physician who documents the necessity for the item, including the expected duration of its use;

b. can withstand long-term repeated use without replacement;

c. is not useful in the absence of an Injury or Sickness; and

d. can be used in the home without medical supervision.

Even when ordered or prescribed by a Physician, Durable Medical Equipment does not include: transcutaneous electrical nerve stimulation (TENS) units, portable ultrasound devices or similar personal medical or therapeutic equipment designed to reduce pain; over-the-counter or customized shoe inserts; computers, tablets, computer applications, or software used in association with communication aides, or internet or phone services used in conjunction with communication devices; sleep apnea machines, regardless of the purpose for their use; air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, or sun and heat lamps; exercise devices; lifts, such as seat, chair or van lifts; customized or motorized wheelchairs; wigs; breast pumps; or items typically available without a prescription (such as compression bandages).

36. **Out-Patient Prescription Drug Benefit:** We will pay the Eligible Expenses, subject to the Coinsurance Percentage shown in the Schedule of Benefits, if any, for a Prescription Drug or medication when prescribed by a Physician on an Outpatient basis.

To be covered under this benefit, the Prescription Drug must be dispensed for the Covered Person's Outpatient use:

a. On or after the Covered Person's Effective Date; and

b. By a licensed pharmacy provider.

This benefit includes injectable drugs and other drugs administered in a Physician's office or other Out-patient setting.

37. **Extension of Accident and Sickness Medical Benefits:**
Continuation Benefits: We will pay the Covered Percentage of Eligible Expenses incurred while Hospital confined for a covered Injury or Sickness for which a Covered Person has a continuing claim on the date his or her coverage terminates, subject to the limitations and Maximum Benefits set forth in the Schedule of Benefits. Benefits payable under this provision will terminate if a Covered Person becomes covered under any other medical coverage for the covered Injury or Sickness for which benefits were continued.

38. **Mental, Behavioral and Neurodevelopmental Disorder Benefit:** If a Covered Person requires treatment for a Mental, Behavioral, or Neurodevelopmental Disorder, We will pay for such treatment as follows:

Benefits for Inpatient Hospital Confinement

When a Covered Person requires Hospital confinement for treatment of a Mental, Behavioral, or Neurodevelopmental Disorder, We will pay the Covered Percentage of Eligible Expenses, up to the maximum duration set forth in the Schedule of Benefits, if any, incurred for such Hospital Confinement. In computing the number of days payable under this benefit, the date of admission will be counted.

Such confinement must be in a licensed or certified facility, including Hospitals.

Benefits for Outpatient Services

We will pay the Covered Percentage of Eligible Expenses, up to the maximum number of visits set forth in the Schedule of Benefits, if any, incurred for Outpatient treatment of a Mental, Behavioral, or Neurodevelopmental Disorder, up to one visit per day.

The Mental, Behavioral, or Neurodevelopmental Disorder must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an Outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

39. **Biologically Based Mental Sickness** means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of Eligible Expenses incurred for treatment of Biologically Based Mental Sickness, including but not limited to:

a. schizophrenia;
b. schizoaffective disorder;
c. bipolar affective disorder;
d. major depressive disorder;
e. specific obsessive-compulsive disorder;
f. delusional disorders;
g. obsessive-compulsive disorders;
h. attention deficit hyperactivity disorder
i. anorexia and bulimia; and
j. panic disorder.

40. Alcohol and Drug Abuse Expense Benefit:

If a Covered Person requires treatment for alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

Benefits for Inpatient Hospital Confinement

When a Covered Person is Inpatient in a Hospital Detoxification Facility for treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of Eligible Expenses, up to the maximum duration set forth in the Schedule of Benefits, if any, incurred for such Hospital Confinement. In computing the number of days payable under this benefit, the date of admission will be counted.

Such Confinement must be in a licensed or certified facility, including Hospitals.

Benefits for Outpatient Services

We will pay the Covered Percentage of Eligible Expenses incurred, up to the maximum number of visits set forth in the Schedule of benefits, if any, incurred for treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on Accreditation of Hospitals or certified by the Department of Health.

Alcohol Abuse is a condition characterized by a pattern of pathological alcohol use with repeated attempts to control its use, and significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse is a condition characterized by a pattern of pathological drug use with repeated attempts to control its use, and significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely Intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

a. monitoring the amount of alcohol and other toxic agents in the individual’s body;
b. managing withdrawal symptoms; and
c. motivating the individual to participate in appropriate addiction treatment programs for Alcohol and Drug Abuse.

41. Emergency Medical Evacuation, Medical Repatriation and Return of Remains:

Medical Evacuation Benefit:

Subject to prior approval from the Program Manager or its authorized representative, We will cover reasonable expenses related to the air evacuation of an injured or sick Covered Person (and a health care provider or escort if such is directed by the attending Physician) to the Covered Person’s Home Country or country of regular domicile, provided the air evacuation:

a. is upon the attending Physician's written certification;
b. results from a covered Injury or Sickness; and
c. does not occur prior to approval from the Program Manager or its authorized representative.

Repatriation Benefit:

Subject to prior approval from the Program Manager or its authorized representative, We will cover reasonable expenses incurred in connection with preparation and transportation of the body of a deceased Covered Person to their place of residence in their Home Country. This benefit does not include transportation expenses of any person accompanying the body.

42. **Extended Coverage Benefit:** Can provide additional coverage of up to 30 days to:

a. Plan Participants who are newly-enrolled students seeking extended coverage prior to the beginning of their very first terms of study with the Participating Organization, or

b. Plan Participants who have completed their final terms of study in the United States and are preparing to return to their Home Country.

Extended Coverage Benefit is not available to Dependents.

Extended Coverage Benefit For Newly-Enrolled Students:

To be eligible for the Extended Coverage Benefit and before any benefits will be paid:

a. a newly-enrolled student must be enrolled in Full-Time Studies at the Participating Organization; and

b. all Premiums must be paid.

Coverage under the Extended Coverage Benefit will become effective on the later of:

a. up to 30 days prior to the beginning of the term;

b. for arriving students, the date the qualifying, newly-enrolled, and arriving student arrives in the United States prior to classes; or

c. for transfer students, the termination date of the student's prior insurance coverage through the previous educational institution.

Extended Coverage Benefit For Plan Participants Concluding their Studies:

To be eligible for the Extended Coverage Benefit and before any benefits will be paid:

a. the Program Manager must receive written request for Extended Coverage prior to the Termination Date of the Plan Participant's coverage as defined in the Termination Date of Coverage section, and

b. all Premiums must be paid.

Coverage under the Extended Coverage Benefit will terminate on the earlier of:

a. 30 days following the Plan Participant's graduation or completion of an educational program, or

b. the date they depart the United States.

EXCEPTIONS AND EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Plan does not provide benefits, nor is any Premium charged, for any Medical Treatment not expressly indicated in the Eligible Expense section or for any Medical Treatment which is excluded, excepted, or limited in the Policy.

For further clarity, please note that the Plan does not provide benefits, nor is any Premium charged, for:

1. Medical Treatment received due to a Pre-Existing Condition, or complication thereof, exceeding benefits provided elsewhere in the Policy. Medical Treatment for covered Pre-Existing Conditions will be payable under the Policy after the Covered Person's coverage has been in force for six consecutive months. Any expense associated with a Pregnancy conceived prior to the Covered Person's Effective Date of Coverage will be limited to the "Preexisting Condition Benefit" maximum shown in the Schedule of Benefits, if any, even if the child is born after the waiting period. Any expense associated with elective termination of a Pregnancy will be limited to the maximum shown in the Schedule of Benefits, if any, regardless of whether the Pregnancy was conceived after the Effective Date of Coverage.
2. Medical Treatment which is:
    a. not Medically Necessary;
    b. provided by individuals affiliated with, employed by, or retained by the Participating Organization, including its athletic department and charges for Sports Psychology, unless provided in a Student Health Center by its providers;
    c. received in, or provided by individuals affiliated with, the Participating Organization's athletic department;
    d. normally provided without charge by an Immediate Family member of, or person who resides at the same legal residence as, the Covered Person;
    e. payable under individual automobile insurance (except for no-fault auto insurance); or
    f. not charged, or for which no payment would be required if the Covered Person did not have this insurance.
3. Medical Treatment for an Injury or Sickness incurred while the Covered Person is engaged in an occupation (whether paid or unpaid) and which is covered under any occupational benefit plan or any Worker's Compensation or similar employer's liability law.
4. Charges in excess of the Preferred Allowance or Usual, Reasonable and Customary charges, whichever applies, or for which the Covered Person received any discount, credit, or reduction.
5. Any of the following:
    a. Hearing aids, eyeglasses, or contact lenses and the fitting or servicing thereof, unless the need for such results directly from an Injury or covered eye surgery.
    b. Transcutaneous Electronic Nerve Stimulation (TENS) units, portable ultrasound therapy units, or similar personal medical or therapeutic equipment designed to reduce pain, even if prescribed by a health care provider.
    c. Customized or motorized wheelchairs.
6. Intrauterine devices (IUDs) and birth control implants, including any procedures related to the placement and/or removal of such.
7. Any elective or preventive surgery, including any Medical Treatment required to prepare for or recover from the surgery or procedure. Examples of excluded surgeries or procedures include, but are not limited to: sterilization procedures; sex transformation surgery or the reversal thereof (including Medical Treatment related to gender dysphoria); breast enlargements; correction or treatment of a deviated septum; or cosmetic, plastic, reconstructive, or restorative surgery.
8. Circumcision or breast reduction for any reason, even if Medically Necessary. However, circumcision of newborns will be governed by the Newborn Infant provision above, if any.
9. Medical Treatment related to solid organ transplants, tissue transplants, or blood/bone marrow transplants (stem cell transplants), whether as donor or recipient. This exclusion includes expenses incurred for the evaluation process, transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ or tissue. In relation to a bone marrow or stem cell transplant, this exclusion includes harvesting and mobilization charges.
10. Medical Treatment for injuries sustained in practice for or participation in Intercollegiate Sports in excess of benefits provided elsewhere in this coverage, if any.

11. Medical Treatment for cessation or deterrence of using tobacco or nicotine.
12. Any expense related to an Accident, Injury, or Sickness caused in whole or party by any act of war, declared or undeclared, or the Voluntary, active participation in a civil war, riot, rebellion, insurrection, or revolution.
13. Medical Treatment for Injury or Sickness sustained while committing or attempting to commit an assault, felony, or other illegal action, or that occurs while being engaged in an illegal occupation.
14. Medical Treatment arising out of aeronautics or air travel, except while riding as a passenger on a regularly scheduled commercial airline.
15. Any charges in excess of benefits provided elsewhere in the coverage, if any, for Injury or Sickness arising from the Covered Person's:
    a. Intoxication;
    b. Use of any drugs or medication:
        i. Not prescribed to them;
        ii. Intentionally taken in an amount other than the dosage recommended by the manufacturer; or
        iii. Intentionally taken for any purpose other than that prescribed by a Physician;
    c. Use of illegal narcotics;
    d. Use or consumption of THC (Tetrahydrocannabinol), regardless of the legality or illegality of its use in the state in which it is used or consumed; or
    e. Doing any of the following, whether sane or insane:
        i. Intentionally self-inflicted action or injury;
        ii. Committing or attempting to commit suicide; or
        iii. Actual or attempted self-destruction.
16. Any of the following which exceed benefits provided elsewhere in the Policy, if any: charges for Medical Treatment received in connection with dental care, orthodontia care, myofascial pain, or temporomandibular joint dysfunction.
17. Any Medical Treatment received in connection with any sleep disorder, including sleep apnea machines.
18. Charges for:
    a. Medical Treatment which is Experimental, Investigational, for research purposes, or part of a clinical Trial.
    b. Medical Treatment for:
        i. Infertility;
        ii. Obesity (including bariatric Surgery and anorectics);
        iii. Acne;
        iv. Alopecia (loss of hair); or
        v. Excessive sweating (hyperhidrosis).
    c. Experimental, compound, or specialty drugs;
    d. Private duty nursing services and Custodial Care.

19. Medical Treatment for Injuries sustained while practicing for or participating in:

a. professional sports;

b. competitive cheerleading; or

c. hazardous or adventure sports of any kind, including but not limited to

Hoverboard usage	Hang gliding
Skydiving	Parachuting
Vehicle racing of any kind	Any rodeo activity
BASE jumping	Kiteboarding
Mountaineering, climbing, or trekking (either without proper equipment or guides, or above elevation 4500 meters above ground level)	Off-piste or off-trail skiing or snowboarding
Motocross or Moto-X	Ski jumping
Luge	Sub-aquatic activities below 50 meters
Whitewater rafting exceeding Class IV difficulty	Cliff jumping

DEFINITIONS

For the purposes of the Policy, the capitalized terms used herein are defined below. Additional terms may be defined within the provision to which they apply. The male pronoun includes the female whenever used.

Accident means an unforeseeable event which:

1. causes Injury to one or more Covered Persons; and
2. occurs while coverage is in effect for that Covered Person.

Allowable Expense means an expense that is:

1. Medically Necessary;
2. Usual, Reasonable and Customary;
3. incurred while the person for whom the claim is made is a Covered Person or is entitled to Benefits after insurance ends, under the Policy; and
4. at least partially covered by any one of the Plans that covers the person for whom claim is made.

When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Application means the Plan Participant's Application for inclusion under the master Policy.

Average Semi-Private Charge means either:

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. an amount equal to 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide semi-private accommodations.

Birthing Center means a facility designed to provide a homelike, nonmedical setting for birth.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits afforded a spouse. Throughout the Policy, use of terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships shall be understood to include Civil Union Partners. Use of terms 'marriage' or 'married' or variations thereon shall be understood to include civil unions.

Claim Determination Period means a calendar year or that part of a calendar year in which the Plan Participant or his or Dependent, if any, has been covered under the Policy.

Coinsurance means the percentage of Eligible Expenses related to a covered service for which the Company is responsible after the copay, deductible, if any, has been met. Coinsurance is separate from and not a part of copay.

Company means Crum & Forster SPC on and behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Copay means a specified charge the Covered Person is required to pay out of their own pocket when a medical service is rendered and before benefits will be paid under the Policy. Copay is separate and not a part of Coinsurance.

Cosmetic Surgery means the surgical alteration of tissue primarily to improve appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable

Covered Loss(es) means an accidental death, dismemberment, or other Injury covered under the Policy and indicated on the Schedule of Benefits.

Covered Person means a Plan Participant covered under the Policy.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living.

Dentist means a legally licensed doctor of dental surgery, dental medicine or dental science. A dental hygienist who works within the scope of their license, under the supervision of a Dentist, is a covered practitioner.

Eligible Expenses means only the expenses actually incurred by a Covered Person for Medically Necessary Medical Treatment which:

- is prescribed by a Physician for therapeutic management of an Injury or Sickness;
- is not excluded by any Policy provisions; and
- does not exceed the Preferred Allowance or Usual, Reasonable and Customary charges, as defined by the Policy.

To be Eligible Expenses, expenses must be incurred while the Policy is in force.

Emergency means an Injury or Sickness for which the Covered Person seeks immediate Medical Treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms sufficiently severe (including severe pain) that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- serious jeopardy to life or health of the individual, or, with respect to a pregnant woman, serious jeopardy to the life or health of the woman or her unborn child;
- serious impairment of bodily functions; or
- serious damage to any bodily organ or part.

Experimental/Investigational.

A drug, device or Medical Treatment will be considered Experimental or Investigational if:

- it is not recognized by the Plan as standard medical care for the condition, disease, Sickness, or Injury being treated, or if other less invasive procedures have not first been pursued;
- the drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration ("FDA") and approval for marketing has not been given at the time the drug or device is furnished;
- the informed consent document utilized with the drug, device, or Medical Treatment states or indicates that the drug, device, or Medical Treatment is part of a clinical trial, experimental phase, or investigational phase or if such a consent document is required by law;
- the drug, device, Medical Treatment, or the patient informed consent document was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device, or Medical Treatment is:
    - the subject of ongoing Phase I or Phase II clinical trials;
    - the research, experimental study, or investigational arm of ongoing Phase III clinical trials; or
    - otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device or Medical Treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment of diagnosis.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device or Medical Treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only:

- published reports and articles in authoritative medical and scientific literature;

- written protocol(s) by the treating facility or other facility studying substantially the same drug, device or Medical Treatment; or
- written informed consent used by the treating facility or other facility studying substantially the same drug, device or Medical Treatment.

Eligible Expenses will be considered in accordance with the drug, device or Medical Treatment at the time the expense is incurred. We will determine if the drug, device, or Medical Treatment is Experimental or Investigational based on the above criteria.

Home Country means the country where a Covered Person has their true, fixed, and permanent home and principal establishment and from which they hold a current and valid passport.

Hospital means an institution licensed, accredited, or certified by the State that meets all of the following conditions:

1. operates as a Hospital pursuant to law for the care or treatment of sick or injured persons;
2. has permanent and full-time in-patient care services;
3. is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
4. provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
5. has a staff of one or more licensed Physicians available at all times;
6. provides organized facilities for diagnosis, treatment, and surgery, either on its premises or in facilities available to it on a pre-arranged basis;
7. is not primarily a nursing care facility, rest home, home for the aged, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such;
8. is not a place for the long-term treatment of drug addiction or alcoholism;
9. is not primarily used for educational or Custodial Care; and
10. is not primarily for rendering treatment or services for mental illness.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

1. the Joint Commission of Accreditation of Hospitals;
2. the American Osteopathic Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided and for which a per diem charge is made by the Hospital.

Immediate Family means a Covered Person's Spouse, Domestic Partner, Civil Union Partner, parent, step-parent, child(ren) (includes legally adopted or step-child(ren)), sibling, grandchild(ren), and in-laws.

Injury means bodily harm which results - independently of sickness or infirmity - from an Accident that occurs after the Covered Person's Effective Date and while the Policy is in force as to the person whose Injury is the basis of the claim. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

Inpatient means a Covered Person confined in a Hospital or other institution for Injury or Sickness and is charged for room and board.

Insurance means the coverage provided under the Policy.

Intensive Care Unit means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intercollegiate Sports means participation in a sports program (including but not limited to involvement in any game, match, exhibition, scrimmage, practice, sanctioned training activity, joint practice, or tryout) in which athletes compete with other universities or colleges and which may or may not be regulated by a collegiate athletic association.

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Covered Person is located at the time of an incident.

Maximum Benefit means the greatest amount of Eligible Expenses the Company will pay for the Covered Person as shown in the Covered Person's Schedule of Benefits.

Medical Treatment means all medical care, treatment, services, supplies, procedures, or drugs that may be administered to a Covered Person to address a sickness or injury.

Medically Necessary or **Medical Necessity** refers to Medical Treatment that is:

1. Required, necessary, and appropriate for the diagnosis or treatment of an Injury or Sickness;
2. Prescribed or ordered by a Physician or furnished by a Hospital;
3. Performed in the least costly setting required by the condition;
4. Consistent with medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, Medically Necessary means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. Under those circumstances, We may consider the cost of the alternative to be the Eligible Expense.

Purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A Medical Treatment shall not be considered Medically Necessary if it:

- is Experimental/Investigational or furnished in connection with medical research;
- is provided for education purposes or the convenience of the Covered Person, or the Covered Person's family, Physician, Hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care necessary to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a service, supply, medical device, drug, or substance:
    - not formally approved by the United States Food and Drug Administration;
    - considered not payable by the Centers for Medicare and Medicaid Services;
    - not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
    - can be safely provided to the patient on a more cost-effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental, Behavioral, and Neurodevelopmental Disorders means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

Natural Teeth means the major portion of an individual tooth which is present, regardless of filings and caps, and is not carious, abscessed, or defective.

Network Provider means a Physician, Hospital, or other healthcare provider who has contracted to provide specific medical care at negotiated prices.

The availability of specific providers is subject to change without notice. You should always confirm that a Network Provider is participating at the time services are rendered by asking the provider when you make an appointment for services.

Non-Network Provider means a Physician, Hospital, or other healthcare provider who has not agreed to any pre-arranged fee schedules. A Covered Person may incur significant out-of-pocket expenses with these providers. Charges for Non-Network Providers which exceed the insurance payment are the Covered Person's responsibility.

Outpatient means a Covered Person who receives Medical Treatment in a Hospital or other institution, including; ambulatory surgical center; convalescent/ Skilled Nursing Facility; or Physician's office, for an Injury or Sickness, but who is not confined and is not charged for room and board.

Out-of-Pocket Maximum means the maximum dollar amount the Covered Person is responsible to pay per Policy Year. After the Covered Person has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Year. The Out-of-Pocket Maximum is met by payment of accumulated Deductible, Coinsurance and Copays. Penalties and amounts above the Preferred Allowance or Usual, Reasonable and Customary Expenses which are paid by the Covered Person do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Participating Organization means any organization which elects to offer coverage by completing a Participation Agreement and that has been approved by the Company to sponsor coverage under the Policy.

Participation Agreement means the agreement completed by a Participating Organization for insurance under the master Policy.

Physician means a legally licensed practitioner of the healing arts who is practicing within the scope of their license while performing a particular service covered under the Policy. For sake of clarity, Physician includes Nurse Practitioners and Registered Dieticians. Physician does not include:

- a practitioner of chiropractic, naturopathic, naprapathic, or alternative medicine;
- an athletic trainer;
- a nutritionist who is not also a Registered Dietician;
- any Covered Person;
- a Close Relative of a Covered Person; or
- an individual residing at the same legal residence of the Covered Person.

Plan Participant means a Person eligible for coverage as identified in the Enrollment/Application for whom premium payment has been made when due and who:

- is not a United States Citizen;
- is traveling outside their Home Country;
- has their true, fixed, and permanent home and principal establishment outside of the United Sates; and
- holds a current and valid passport.

Policy means the Policy document, Policyholder's and the Participating Organization's Application, and any end endorsements, riders or amendments that attach during the Period of Coverage.

Policy Period means the period of time between the Policy's Effective Date and its Expiration Date, as shown on the Schedule of Benefits.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition about which the Covered Person:

- Consulted a Physician;
- Received a recommendation for a test, examination, or Medical Treatment;
- Received a test, examination, or Medical Treatment; or

- took or received a prescription for drugs or medicine

during the 6 month period immediately preceding the Covered Person's Effective Date of Coverage.

However, a condition which is treated or controlled solely through Prescription Drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6 month period before the Effective Date of Coverage is not a Preexisting Condition.

Pregnancy means the physical condition of being pregnant.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law and are approved for general use by the Food and Drug Administration.

Registered Nurse or Nurse means a licensed professional Registered Nurse (R.N.). Registered Nurse does not include:

- any Covered Person;
- a Close Relative of a Covered Person; or
- an individual residing at the same legal residence as the Covered Person.

Service Provider means a Hospital, convalescent/Skilled Nursing Facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means a sickness or disease which is contracted and causes loss while the Policy is in force as to the Covered Person whose Sickness is the basis of a claim. Any complication or any condition arising out of a Sickness for which the Covered Person is receiving or has received Medical Treatment will be considered part of the original Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing care 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Sports Psychology means the use of psychological applications in helping an athlete increase their performance in any level of sport or athletics.

Spouse means lawful spouse, if not legally separated or divorced, domestic partner, or Civil Union Partner.

Student Health Center means an ambulatory care facility affiliated or contracted with the Participating Organization that, at a minimum, maintains a staff consisting of a nurse director/nurse practitioner and/or staff Nurses, and may have either a staff Physician or an arrangement with a Physician to perform office visits or engage in a collaborative practice arrangement with a mid-level provider at the center. If the Participating Organization does not have a Student Health Center, the Participating Organization may request permission from the Program Manager to designate a Walk-In Pharmacy Clinic to be treated as a Student Health Center for the purposes of the Policy.

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Third Party means a person or entity other than the Covered Person, Policyholder, Participating Organization or Company.

Usual, Reasonable and Customary (URC) means the most common charge for similar Medical Treatment, professional services, or devices within the area in which the charge is incurred. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate, if any; or

- the charge which would have been made by the provider (Physician, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonably determined by Us for the same service or supply.

"Geographic Area" means the three-digit zip code in which the Medical Treatment, professional services, or device are provided or a greater area if necessary to obtain a representative cross-section of charge for a like Medical Treatment, professional services, or device.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy means the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

Utilisation of Nuclear, Chemical, or Biological weapons of mass destruction shall mean:

- the use of any nuclear weapon or device; or
- the emission, discharge, dispersal, release or escape of:
    - fissile material emitting a level of radioactivity, or
    - any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesised toxins), or
- distribution of any solid, liquid or gaseous chemical compound which is capable of incapacitating, disabling, or killing people or animals.

Walk-In Pharmacy Clinic means a clinic located inside a larger retail operation, such as a pharmacy or retail store, and which provides basic care for minor injuries and sicknesses, and may provide vaccinations, immunizations, annual physicals, health screenings, and diagnostic tests.

We, Our, Us means Crum & Forster SPC on behalf of ITI SP.

You, Your, Yours, They, Their, or Theirs means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY AND PARTICIPATION

For the purposes of plan eligibility…

- A student is actively engaged in Full-Time Studies if, based on the student's attendance and participation, they are eligible to receive a completed grade or credit in all of their courses at the conclusion of the relevant term.
- To be considered as "full-time," the student must be enrolled and actively engaged in at least the minimum number of credit hours required per the terms of the student's visa (F-1, M-1, J-1). Consult the definition of an Eligible Student in the Policy for more information.
- The student must begin the term actively attending class for up to 31 consecutive days following the beginning of the then-current term, unless the student is unable to attend class due to an acute bodily infirmity or Injury. Please refer to the definition of an Eligible Student in the Policy.
- The student must continuously maintain status under their applicable visa type. In the event a student fails to continuously maintain their status, the school or its designated student advisor must work with the student in taking the necessary steps to bringing the student's student visa back to status. Failing to maintain student visa status will put the student out of status and will make the student ineligible for coverage.

Upon receipt of premium, participating Eligible Students are covered under the Plan anywhere in the world except their Home Country.

Insurance eligibility can be verified with medical providers upon receipt of enrollment.

Students should maintain their health insurance coverage during breaks and vacation periods in order to avoid gaps in coverage and being subject to pre-existing condition limitations.

United States citizens and residents are not eligible for coverage. Company agrees to provide the insurance benefits described in the Policy in consideration for the Policyholder's Application, the Participating School's application, and payment of all Premiums when due. The Policy will become effective on the first day of the Policy Term shown in the Policy's Schedule of Benefits.

IMPORTANT INFORMATION

Important notices regarding the Patient Protection and Affordable Care Act (PPACA)

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA-compliant health insurance coverage. This plan is not designed to cover US residents and citizens. This policy is not subject to guaranteed insurance or renewal.

Membership in Trust

By purchasing this insurance provided by Crum & Forster SPC, under the jurisdiction of the Cayman Islands, you become a member of the Fairmont Specialty Trust. A copy of the subscription agreement is attached hereto.

Data Protection

Please note that sensitive health and other information you provide may be used by Us, Our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates for both disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

THIS IS A LIMITED BENEFIT POLICY.

Please read it carefully. The Policy is nonparticipating.

The insurance described in this document provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

No legal action may be brought to recover on the Policy unless at least 60 days after written Proof of Loss is furnished. No legal action may be brought after three years from the time written Proof of Loss is required to be furnished.

Complaints

Every effort is made to provide you a high standard of service. However, occasionally disputes or misunderstandings arise and you need to know what to do. If you wish to make a complaint, your complaint should be made in writing to the Program Manager at:

The Lewer Agency, Inc.
Attn: Claims Department
9900 W. 109th Street, Suite 200,
Overland Park, KS 66210

Toll Free: 800-821-7710