LewerMark®

Plan Brochure

2025-2026

Siena Heights University

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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:

SiriusPoint International Insurance Corporation *(the "Company")*

UK Branch | 33 Gracechurch Street | London EC3V 0BT, UK

Policy Number: LM-8675309-793

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/sienaheights
- The Lewer Agency, Inc. | Student Insurance | 9900 W 109th St. Suite 200 | Overland Park, KS 66210

TELADOC

Teladoc is a convenient and affordable option that allows you to talk to a doctor or therapist who can diagnose, recommend treatment, and prescribe medication, when appropriate, for many mental health and medical issues.

- Download: FREE **TELADOC** app from your device's app store today
- Web: teladochealth.com
- 24/7 Care Toll Free: **1 (800) 835-2362**
- Mental Health Complete Toll Free: **1 (877) 419-2378**

TOGETHERALL

Togetherall's 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: togetherall.com
- 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 Find an Aetna Provider

TELADOC

Quality Care + Convenience

Telehealth 24/7 Care

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

- Sinus problems
- Bronchitis
- Allergies
- Cold and flu symptoms
- Respiratory infection

Contact TELADOC 24/7/365 • Toll-Free: 1(800) 835-2362

Mental Health Complete

This student assistance program is designed to support international students to resolve mental and physical health concerns. Teladoc's friendly and caring licensed therapists and psychiatrists are available to help with a broad range of mental health needs, including prescribing medications. Additional resources include live coaching, digital programs, diverse language providers, and 24/7 crisis care. Students can call or video chat with no limit.

Counseling and psychiatric support provided for:

- Adapting to new cultures
- Managing anxiety, depression, & negative thoughts
- Grief, loss, PTSD, OCD, & mild disordered eating
- Promoting wellness & resiliency
- Stress, adjustment, sleep, relationships, and more

Additional Resources:

- Live coaching
- Digital Programs
- Diverse language providers
- 24/7 crisis care
- No out-of-pocket cost

Contact TELADOC Mental Health Complete • Toll Free: 1 (877) 419-2378

Download the TELADOC App! www.teladoc.com

GET IT ON Google Play

Download on the App Store

TOGETHERALL

togetherall

Online Community Support

Togetherall is a safe online community you can share feelings anonymously and get support to improve your 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 immediately contact Scholastic Emergency Services (SES) if there is a life-threatening emergency or illness **SES will not reimburse you for services; instead, SES arranges and pays for the services itself.** You must contact SES immediately so SES can arrange for necessary services.

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

SES will make all arrangements to provide 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**

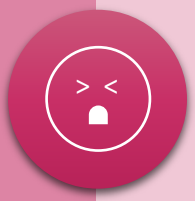
URGENT CARE VS. EMERGENCY ROOM

Where should I go when I'm sick?

It can be difficult to know where to get treatment when you're sick. We've made a list of suggestions below – we hope this helps!

STUDENT HEALTH CENTER OR URGENT CARE

- Colds, Coughs, and Sore Throats
- Earaches
- Minor Cuts
- Potential Muscle / Ligament Strain
- Sunburn / Minor Cooking Burn
- Itchy Skin / Rashes
- Fever / Flu
- Sexually Transmitted Diseases
- Pregnancy Testing
- Problems with Urination



EMERGENCY ROOM

- Loss of Consciousness
- Intolerable / Uncontrollable Pain
- Shortness of Breath
- Chest Pain / Pressure
- Poisoning
- Major Injuries / Broken Bone
- Severe or Worsening Allergic Reaction
- Unable to Move
- Severe Bleeding
- Deep Cuts Requiring Stitches

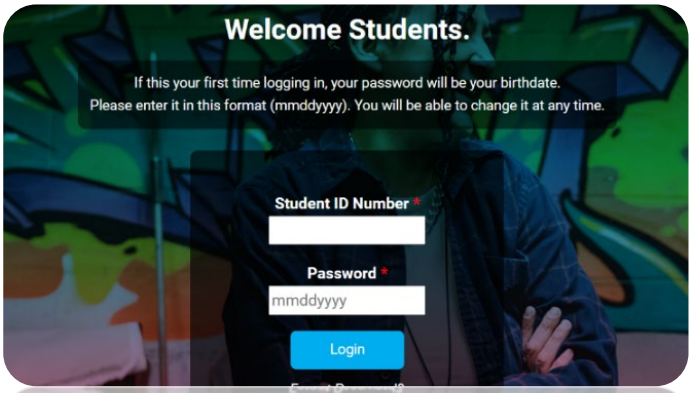
Note: LewerMark does not offer medical advice. This information is presented to help international students better understand the U.S. health care provider and delivery system. In all situations, you should rely on your own best judgement in choosing when and where to receive health care services.

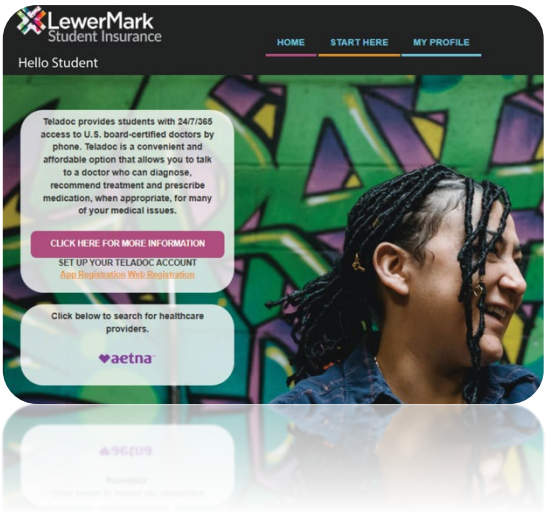
LOGGING INTO YOUR STUDENT ACCOUNT

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

Type your student ID number in the space provided. Nine digits are required for a valid ID number; if your ID number is shorter than 9 numbers, add zeros to the beginning of the number. *For example, 001234567.* If your ID number 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.*



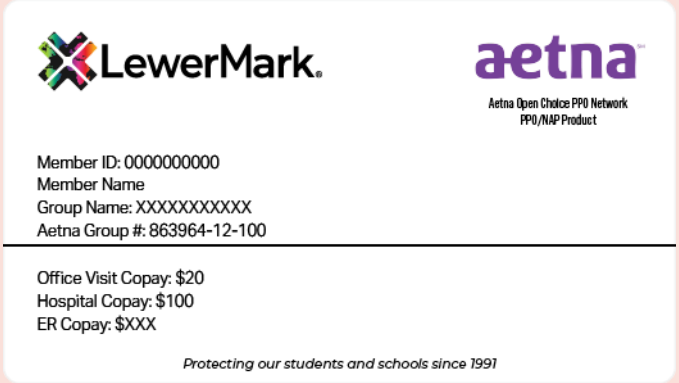


The first time you log in, you will be prompted to change your password and add a security question. **Do not skip this step.** When you log back into your account you will use your new, unique password.

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

We recommend keeping a copy of your ID card on your phone, so you always have it with you! You will use your card when you go to a doctor or pharmacy.

Front of the ID card



Back of the ID card

If you experience difficulty logging in to your account or retrieving your ID card, contact our Client Advocacy Team through our chat feature at lewermark.com, by phone at 1 (800) 821–7710, or by email 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.

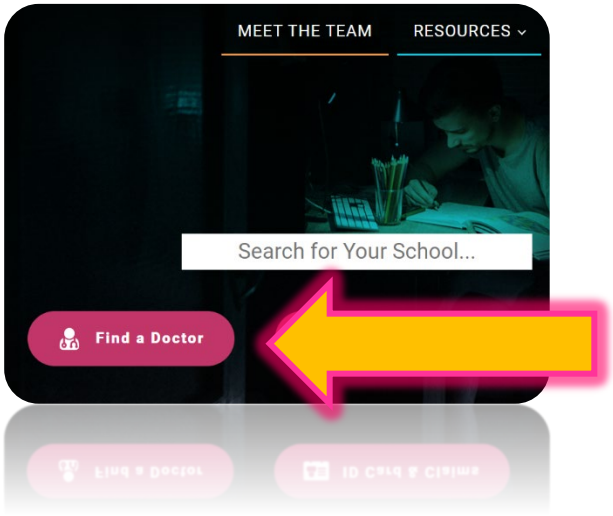
Click the "**Find a Doctor**" button.

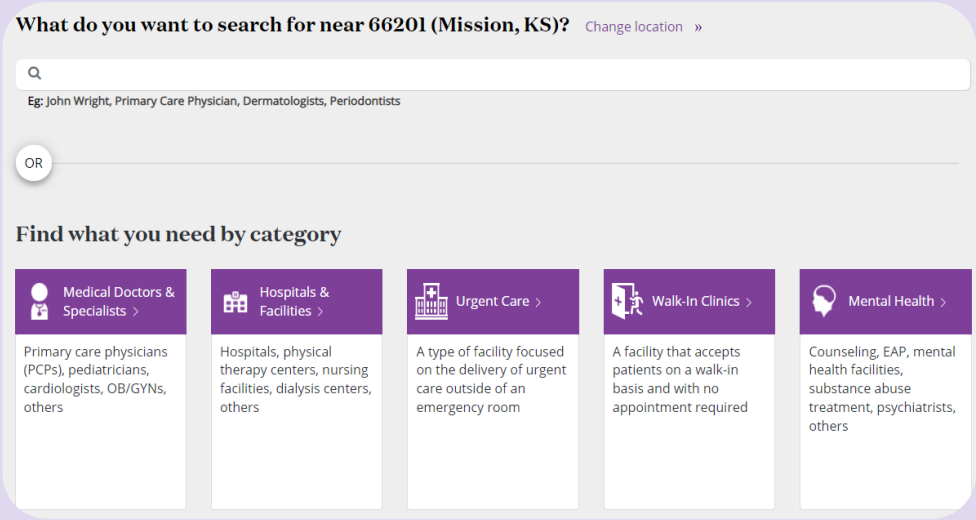
Click "**Find an AETNA Provider**".

Enter your city or zip code in the space that reads,

"**Enter location here**".

Select "**Passport to Healthcare Primary PPO Network**". Additional options may be available by selecting "Passport to Healthcare Secondary PPO Network".



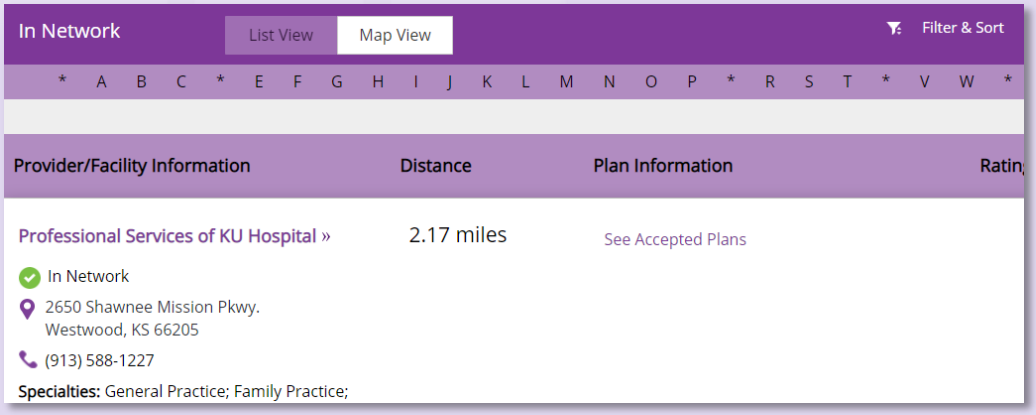


From this screen, you can see if a doctor is in-network by typing their name next to the magnifying glass.

If you select "**Medical Doctors & Specialists**" and then "**Doctors (Primary Care)**" and then "**General Practice**", you will receive a list of doctors in-network. You may also search by category for the type of doctor or medical care facility you would like to visit.

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

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



If you need help finding a doctor or hospital, contact our Client Advocacy Team through our chat feature at lewermark.com, by phone at 1 (800) 821–7710, or by email at lewermarksupport@lewer.com.

WHAT IS A CLAIMS QUESTIONNAIRE?

You may receive an email requesting a questionnaire after you visit the doctor or go to 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: * _____

For assistance : Call: 1-800-821-7710 Email: lewermarksupport@lewer.com Chat with us: www.lewermark.com

Name of condition or injury: *

How did your injury, accident, illness, or other condition occur?

*

How did the injury happen? *Select...

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

Have you ever been treated for this condition before? * ◯ Yes * ◯ No First date Last date

If yes, when was the first and last time you were seen or treated by the doctor for this condition?

List all medications that you are currently taking and dates you started taking them:

Need to complete a Claims Questionnaire? Complete and submit your Claims Questionnaire at www.lewermark.com/claim-forms.

Notice and Proof of Claim - Timely Filing Requirement

The Policy requires written proof of loss 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 and 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 will 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 year after the date of service. If a claim is timely filed, but the plan's Program Manager requests additional documentation, the healthcare provider has up to one year to submit the requested information.

SCHEDULE OF BENEFITS

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

The Schedule of Benefits provides a brief outline of the coverage and benefits provided by the Policy. The benefits summarized in this Brochure may be subject to definitions, exclusions, and provisions. Please see the Policy for full details.

Eligible Student

An Eligible Student is a registered and enrolled student of a Participating School who is all of the following:

1. a legal resident of a country other than the United States, its territories, or possessions;
2. 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.

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 Covered Dependent and a Covered Student at the same time.

The Policy does not provide students an insured term off. However, an extra-contractual accommodation may be available, subject to prior written approval by the carrier. Insured terms off may be available in only two circumstances: for medical necessity or vacation. Insured terms off are limited to one term per school year. A "term" refers to a single session of the school's academic year (e.g., a school on a semester system has three terms – fall, winter, and summer – and a school on a trimester or quarterly system has four terms – fall, winter, spring and summer). A student may not utilize an insured term off for both medical necessity and vacation in a single academic year. The carrier reserves the right, in its sole discretion, to approve or decline any request for an insured's term off. If a request for an insured term off is permitted, the Covered Student will be required to pay all applicable premium for the insured term off.

Visiting Faculty and Scholars

This section applies exclusively to individuals holding an Exchange Visitor non-immigrant visa, otherwise referred to as a J-1 visa.

J-1 visa holders who possess and maintain current passports and valid J-1 visa status may be considered for coverage under the Policy if engaged in educational activities with the Participating School.

J-1 visa holders will have access to all policy benefits and limits and will be subject to all Policy exceptions and exclusions. In addition, in compliance with Department of State requirements, insured J-1 visa holders who exhaust the stated Policy Year Maximum Benefit will have access to additional J-1 medical benefits of $100,000 per accident or illness. These additional J-1 medical benefits will be subject to all Policy terms, internal benefit limits, exceptions, and exclusions.

Optional Practical Training

An eligible Optional Practical Training ("OPT") student who holds the applicable F-1 visa may be eligible for coverage after graduation while the student participates in OPT work directly related to the 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. All other OPT extension students are eligible for a maximum of twelve months coverage from the date the student is approved for OPT.

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

SCHEDULE OF BENEFITS

The Policy provides different levels of benefits and Copays depending on where the Covered Person chooses to receive care or whether the Covered Person uses the services of a Participating Provider. A Covered Person may use the provider of their choice, but this decision may result in additional out-of-pocket expenses. The following benefits are available, per Covered Person, up to the amounts shown.

POLICY BENEFITS – PER COVERED STUDENT	
Policy Year Maximum Benefit	$500,000
Lifetime Maximum Benefit per Covered Injury or Covered Sickness	$500,000
Annual Deductible- Applies to all Covered Benefits except to Prescription Drugs and Medical Treatment received at Student Health Centers or CVS Minute Clinic	$100
Policy Year Out-of-Pocket Expense Maximum	$6,000
Pre-Existing Condition Benefit – First six months of continuous coverage Pre-Existing Pregnancy Coverage: Benefits for expenses associated with a Pregnancy conceived prior to the Effective Date of Coverage will be limited to the Pre-Existing Benefit maximum	$1,000

COPAYS	In-Network or Out-of-Network
Student Health Center, Telehealth, or CVS Minute Clinic Visit	$0
Office Visit	$20
Hospital Visit or Admission	$100
Hospital Emergency Room (waived if admitted)	$100

COINSURANCE (applies to all Covered Benefits)	
In-Network Provider	90% of Allowed Charge
Out-of-Network Provider	70% of Reasonable and Customary Expenses

COVID-19 COVERAGE
Treatment for COVID-19 (coronavirus) is covered.
Medically necessary, diagnostic testing for COVID-19 is covered.
COVID-19 VACCINE
The COVID-19 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
Dispensed while Inpatient at a Hospital or by a Hospital Emergency Room	90% In-Network or 70% Out-of-Network
Outpatient Prescription Drug Benefit Maximum	$2,500 per policy year
With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30-day supply, until the Prescription Drug Benefit Maximum has been met.	

Payments toward the Prescription Drug Benefit Maximum will not count toward satisfying the Policy Out-of-Pocket Expense Maximum.

CONTRACEPTIVE BENEFITS	At Student Health Centers and In-Network Providers	Out-of-Network
Oral Prescription Contraceptives	100% of each 30-day supply	Not covered
Non-Oral Prescription Contraceptives	100% at Student Health Center or 50% at other In-Network Providers	Not covered
There is no coverage for intrauterine devices (IUDs) or birth control implants and procedures related to placement and/or removal of such.		

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

SCHEDULE OF BENEFITS

COVERED BENEFITS	In-Network	Out-of-Network
Hospital Room and Board at Semi-Private Room Rate	90%	70%
Intensive Care Unit (Average Charge)	90%	70%
Urgent Care	90%	70%
Outpatient Medical Care and Supplies	90%	70%
Pregnancy (Conception must occur while covered under the Policy)	90%	70%
Laboratory, X-Ray, and Diagnostic Examinations	90%	70%
Professional Ground or Air Ambulance for Emergency Services	90%	90%
Infusion Therapy	90%, up to a maximum of $10,000 per policy year	70%, up to a maximum of $10,000 per policy year
Renal Dialysis/Hemodialysis	90%, up to a maximum of $10,000 per policy year	70%, up to a maximum of $10,000 per policy year
Medical Treatment of a Mental Condition	Inpatient – Aggregate maximum of 30 days per policy year Outpatient – Aggregate maximum of 30 visits per policy year	
Medical Treatment of Alcoholism or Drug Dependency	Inpatient – Aggregate maximum of 30 days per policy year Outpatient – Aggregate maximum of 30 visits per policy year	
Wellness Benefit (Not subject to Copay or Deductible)	100% up to a Maximum Benefit of $500 per policy year	
STD Testing	90%	70%
Tuberculosis Testing	Included in the Wellness Benefit	
Immunization	Included in the Wellness Benefit	
Outpatient Physiotherapy (Only when prescribed in writing by a Physician)	Up to 20 visits per policy year A Copay applies for each visit	
Acupuncture and Chiropractic (Only when prescribed in writing by a Physician)	Up to $50 per visit after satisfaction of Copay Maximum Benefit of 12 visits of either acupuncture, chiropractic care, or any combination of the two per policy year	
Home Country Coverage	$1,500 per policy year	
Club/Intramural/Recreational Sports	90%	70%
Intercollegiate Sports Benefit	$10,000 per policy year	
Self-Inflicted Injury	$15,000 per policy year	
Elective Termination of Pregnancy	Up to $1,000 per policy year	
Dental Injury	Up to $2,500 per policy year	
Palliative Treatment of Dental Pain	Not covered	
Continuation of Coverage	Available up to a maximum of 13 weeks or up to a Maximum Benefit of $10,000, whichever is reached first	
Medical Evacuation	Up to $50,000 of Reasonable Expenses	
Repatriation	Up to $25,000 of Reasonable Expenses	

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

Applies only to Covered Students (dependents ineligible for coverage).
Coverage terminates at age 65.

Principal Sum: $10,000

Loss must occur within 90 days of the Covered Accident

COVERED 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 Plan Participant suffers a Covered Loss, We will pay the percentage of the Principal Sum set opposite the loss in the table above. If the Plan Participant sustains more than one Covered Loss as the result of a single Accident, We will pay only one amount, the largest to which they are entitled. This amount will not exceed the Maximum Benefit Amount shown in Schedule of Benefit.

Benefits are payable if such Injury occurs while the Plan Participant is covered under the Policy and the Accident or Injury does not result – in whole or in part – from the Plan Participant's:

- Suicide;
- Attempted suicide; or
- Overdose on:
  - Drugs, whether prescribed to the Plan Participant or not;
  - Alcohol; or
  - Any combination of the two.

COVERED MEDICAL EXPENSES

Company will pay benefits subject to the exclusions, limitations, and all other provisions of the Policy, for a Covered Expense if:

- the Copay or Deductible, if any, is met;
- the expense is incurred due to a Covered Injury or Covered Sickness; and
- the Covered Person has not exceeded the Policy's benefit maximums.

Company will consider each Covered Expense to be incurred on the date the medical care or supply is received. Pursuant to determining eligibility for benefits and subject to the limits shown in the Schedule of Benefits, the Policy will pay benefits for the following Covered Expenses:

1. **Medical Treatment:** Diagnosis and Medical Treatment by a Physician or Registered Nurse.
2. **Inpatient Hospital Charges:** Daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge or Intensive Care Unit charges.
3. **Outpatient Hospital Charges:** Medical Treatment received at a Hospital on an outpatient basis, including medical supplies used on the premises of a Hospital.
4. **Home Health Services:** 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 Covered Expenses under the Policy. Physical Therapy services are not home health care services.
5. **Diagnostic Examinations:** Laboratory, x-ray, diagnostic imaging, and other diagnostic examinations.
6. **Prescription Drugs:** as shown in the Schedule of Benefits.
7. **Urgent Care:** Care received in an urgent care center or facility.
8. **Emergency Ambulance Service:** Professional ambulance assistance for Emergency Services or required in connection with an Emergency Medical Condition by ground or by air to a Hospital. (See Medical Evacuation Benefit for air service to a Covered Person's Home Country.)
9. **Durable Medical Equipment**: If, by reason of Injury or Sickness, a Covered Person requires use of Durable Medical Equipment ("DME"), We will pay the Covered Percentage of Eligible Expenses incurred by the Covered Person for purchase or rental of Medically Necessary DME. In no event will we pay rental charges in excess of the purchase price of a piece of DME. Any rental charges paid will be applied toward the cost of the purchase price if the DME is purchased at a later date. Please see the Policy for examples of equipment covered under this benefit. We do not pay for replacement of Durable Medical Equipment.
10. **Mental, Behavioral, and Neurodevelopmental Disorders.** In or out-patient Medical Treatment of a Mental, Behavioral, and Neurodevelopmental Disorder in either an individual or group setting. Please see the Policy documents for examples of services covered under this benefit.
11. **Alcoholism or Drug Dependency** In or out-patient Medical Treatment of alcoholism or drug dependency in either an individual or group setting.
12. **Coronavirus Disease 2019 (COVID-19) Benefit.** Medically Necessary diagnostic testing, Medical Treatment, vaccinations, and booster vaccinations related to the COVID-19 coronavirus or any variants.
13. **Wellness Benefit.** Any combination of the following, up to the Wellness Benefit maximum shown in the Schedule of Benefits: routine physical or health examinations, sports physicals, 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, tuberculosis tests and elective COVID-19 tests.

14. **Physiotherapy, Acupuncture, and Chiropractic Benefits:** Physiotherapy, Acupuncture, and Chiropractic services prescribed by a Physician, which are incurred while not Hospital confined, and which are billed by a Physician, chiropractor, or physiotherapist. Charges in excess of the maximums set forth in the Schedule of Benefits shall not be Covered Expenses under the Policy. Physiotherapy charges may include treatment and office visits connected with physical therapy, occupational therapy, and/or speech therapy when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, or acupuncture. 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.

15. **Pregnancy Benefits:** Pregnancy coverage includes 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 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 Pregnancy Benefits, conception must have occurred following the Effective Date of the Covered Person's coverage and the Covered Person's coverage cannot have been terminated for any reason. If the Covered Person is eligible for Pregnancy Benefits, benefits will be payable on the same basis as Covered Expenses for any other Covered Sickness. Global billing of maternity and prenatal care will not be accepted without an accompanying flowchart.

    The Policy does not provide coverage for midwives; care 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 a birthing center; or the purchase or rental of a breast pump, even if prescribed by a physician.

16. **Post-Mastectomy Coverage:** A Medically Necessary mastectomy which may also include coverage of the following:

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

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

17. **Medical Evacuation Benefit:** Subject to prior approval from Program Manager or its authorized representative, 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 Covered Sickness; and
    c. does not occur prior to the benefit approval.

18. **Repatriation Benefit:** Subject to prior approval from Program Manager or its authorized representative, reasonable expenses incurred in connection with preparing and transporting 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.

19. **Continuation Benefits:** For Covered Expenses incurred, while Hospital confined for a Covered Injury or Covered Sickness for which a Covered Person has a continuing claim on the date their coverage terminates. Benefits payable under this provision will terminate if a Covered Person becomes covered under any other medical coverage for the Covered Injury or Covered Sickness for which benefits were continued.

20. **Radiation Therapy and Chemotherapy:** Covered Expenses for radiation therapy, infusion therapy, and chemotherapy or for oral chemotherapy drugs which are prescribed and administered by a licensed Physician. Prior authorization is not required.

21. **Infusion Therapy:** Covered Expenses for infusion therapy for chronic conditions prescribed and administered by a licensed Physician. Infusion therapy required for cancer and cancer-related conditions will be considered under the Radiation Therapy and Chemotherapy provision.
22. **Renal Dialysis/Hemodialysis:** Covered Expenses for Renal Dialysis/Hemodialysis prescribed and administered by a Physician.
23. **Allergy Treatment:** Covered Expenses for Medically Necessary treatment of allergies, as diagnosed and prescribed by a Physician.
24. **Injectable and Provider-Administered Drugs:** Injectable drugs and other drugs administered in a Physician's office or other outpatient setting.
25. **Diabetes Coverage:** Covered Expenses for medical supplies, equipment, and education for diabetes care.
26. **Skilled Nursing Facility:** Covered Expenses for items and services received as an inpatient in a skilled nursing bed of skilled nursing facility or Hospital, including semi-private room and board accommodations; rehabilitative services; drugs; biologicals; and supplies furnished for use in the Skilled Nursing Facility; and other Medically Necessary services and supplies. Benefits are limited to 30 days per policy year. Custodial or residential care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of hospice care.
27. **Dental Injury Benefit:** Medical Treatment of Sound Natural Teeth damaged as the result of a Covered Injury. This benefit does not cover damage to previously decayed teeth caused by chewing or biting.
28. **Home Country Coverage Benefit:** Medical Treatment incurred in the Covered Student's Home Country related to a Covered Injury or Covered Sickness which occurred, was diagnosed, and was treated outside the Covered Student's Home Country during the period of coverage, provided the Covered Student remains on the Participating School's I-20, for a maximum of 90 days on an approved vacation term. Coverage will terminate when the individual permanently returns to their Home Country of permanent residence.
29. **Club/Intramural/Recreational Sports Benefit:** Charges related to a Covered Injury arising out of practice for or participation in Club Sports, Intramural Sports, or Recreational Sports.
30. **Intercollegiate Sports Benefit:** Charges related to a Covered Injury arising out of practice for or participation in Intercollegiate Sports.
31. **Elective Termination of Pregnancy Benefit:** Covered Expenses related to the procedure for an elective termination of a pregnancy. If the Covered Person experiences complications from the procedure, the Covered Expenses will be assessed the same as any other Covered Benefit.
32. **Self-Inflicted Injury Benefit:** Medical Treatment required as the result of suicide, attempted suicide, drug or alcohol overdose, self-destruction, attempted self-destruction, an intentionally self-inflicted injury or other intentionally self-inflicted action occurring while sane or insane in excess of benefits provided elsewhere in the coverage, if any.

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 Covered Expense section or for any Medical Treatment which is excluded, excepted, or limited in the Policy.

For further clarity, 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, if any. 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 Pre-existing 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 not Medically Necessary;
   - is provided by individuals affiliated with, employed by, or retained by the Participating School, including its athletic department and charges for Sports Psychology, unless the Medical Treatment is provided in a Student Health Center by its providers;
   - is normally provided without charge by a Close Relative of the Covered Person;
   - is payable under individual automobile insurance (except for no-fault auto insurance); or
   - is not charged or for which no payment would be required if the Covered Person did not have this insurance.
3. Medical Treatment required for any Covered Injury or Covered Sickness incurred while the Covered Student 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. Expenses in excess of the Reasonable and Customary charge, or to the extent the Covered Person received any discount, credit, or reduction;
5. Intrauterine devices (IUDs) and birth control implants, including any procedures related to the placement and/or removal of such;
6. Any of the following:
   - Hearing aids, eye glasses, or contact lenses and the fitting or servicing thereof, except that the Policy will cover these expenses if the need for such results directly from a Covered Injury or covered eye surgery;
   - Transcutaneous Electrical 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;
   - Customized or motorized wheelchairs.
7. Any elective or preventive surgery or procedure, 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 enlargement; 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 provisions above, if any;
9. Medical Treatment related to organ or tissue 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 would include harvesting & mobilization charges;

10. Medical Treatment related to learning disabilities;
11. Immunizations (except as expressly listed in Covered Expenses), allergy tests, and vitamins;
12. Medical Treatment for injuries sustained in practice for or participation in Intercollegiate Sports in excess of benefits provided elsewhere in this coverage, if any;
13. Medical Treatment for injury or sickness sustained while taking part during the commission or attempt 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, in excess of benefits provided elsewhere in the coverage, if any;
15. Medical Treatment received in connection with any of the following which exceeds benefits provided elsewhere in the Policy, if any: dental care, orthodontia care, myofascial pain, or temporomandibular joint disfunction;
16. Medical Treatment for injuries sustained while:
    - practicing for or participating in semi-professional or professional sports or competitive cheerleading; or
    - participating in 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; cliff jumping; rock jumping; kiteboarding; mountaineering, climbing, or trekking (either without proper equipment or guides, or above elevation 4500 meters above ground level); luge; motocross; Moto-X; ski jumping; off-piste or off-trail skiing or snowboarding; sub-aquatic activities below 50 meters; and whitewater rafting exceeding Class IV difficulty;
17. Medical Treatment for injury or sickness sustained by reason of a motor vehicle or motorcycle accident
    - to the extent benefits are payable or paid by any other valid and collectible insurance (including any automobile or any other insurance coverage purchased by the Covered Person or an involved third-party) whether or not claim is made for such benefits;
    - if the Covered Person was operating the motor vehicle or motorcycle while intoxicated or impaired under the laws of the state in which the accident occurred;
    - if the Covered Person was operating the motor vehicle or motorcycle without a driver's license or permit recognized as valid under the laws of the state in which the accident occurred;
    - if the Covered Person was not operating the motor vehicle or motorcycle in conformity with the restrictions of the driver’s license or permit;
    - to the extent the Covered Person was driving a vehicle without the minimum auto liability insurance required by the law of the state in which the accident occurred;
    - to the extent the Covered Person was in violation of helmet law requirements in the state in which the accident occurred; or
    - to the extent the Covered Person was in violation of any law of the state in which the accident occurred regarding operation of the motor vehicle.
18. Medical Treatment in excess of benefits provided elsewhere in the coverage (if any), for injury or sickness arising from the Covered Person’s:
    - Intoxication;
    - Use of any controlled substance:
        - Not prescribed to them;
        - Intentionally taken in any amount other than the dosage recommended by the manufacturer; or
        - Intentionally taken for any purpose other than that prescribed by a Physician;
    - Use of illegal narcotics;
    - Use of THC, regardless of the legality or illegality of its use or consumption in the state in which it was used or consumed;
    - Doing any of the following, whether sane or insane:
        - intentionally self-inflicting an action or injury;
        - a suicide or attempted suicide; or
        - actual or attempted self-destruction.

19. Charges incurred for surgery, drugs, or treatments which are Experimental/Investigational, for research purposes, or part of a clinical trial or for compound, specialty, or Experimental drugs;
20. Medical Treatment for cessation or deterrence of tobacco or nicotine use;
21. Medical Treatment or diagnosis of sleep disorders, including but not limited to apnea monitoring and sleep studies;
22. Medical Treatment intended to correct an abnormal or irregular walking pattern;
23. Medical Treatment for infertility, obesity (including bariatric surgery and anorectics), acne, alopecia (loss of hair), or excessive sweating (hyperhidrosis);
24. Lab specimen handling and delivery fees, after hours and weekend facility fees, medical records access fees, or interprofessional consultation fees (unless related to Emergency Services or COVID testing or treatment);
25. Any of the following: genetic medicine, testing, or screening procedures; genetic surveillance testing; or any other procedures used to determine genetic predisposition. This exclusion applies to, but is not limited to, amniocentesis, risk assessment, preventive and prophylactic measures indicated only by genetic testing, genetic counseling, or gene therapy;
26. Medical Treatment related to any previously known Congenital Condition, regardless whether the Covered Person previously sought treatment for the condition;
27. Private duty nursing and/or Custodial Care;
28. Notwithstanding any provision to the contrary within the Policy or any endorsement thereto, this insurance or any endorsement thereto excludes any loss or expense of whatever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss or expense, unless involved as an innocent bystander;
    - War, or any act or war (whether declared or not), Terrorism, invasion, act of foreign enemy hostilities, warlike operations, civil war;
    - Mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power, civil commotion;
    - Attempted overthrow of government, any act directed towards overthrow of government or influencing any overthrow by violence; martial law or state of siege; or
    - Any use of or exposure to any radiological, chemical, nuclear, or biological weapons or any other radiological, chemical, nuclear, or biological events.

DEFINITIONS

Unless separately defined herein, wherever used in the Policy:

Allowed Charge: the discounted fee the provider Network negotiates with Physicians, hospitals, and other health care providers in the Network.

Area: the location where medical care or supplies are given, within a region large enough to get a cross-section of providers of medical care or supplies, as determined by the Program Manager.

Average Semiprivate Charge: the standard Hospital charge for semiprivate room and board accommodations, or the average of such charges if the Hospital has more than one established level of such charges. If the Hospital does not provide semiprivate accommodations, the Average Semi-Private Charge is, 80% of the lowest charge by the Hospital for single bed room and board accommodation.

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

Close Relative: a Covered Person's spouse, child(ren), siblings, parents, grandparents, and aunts and uncles.

Club Sports: participation in sports as part of a club or team which may or may not be affiliated with the Participating School in which the athletes compete with other similar clubs or teams.

Coinsurance: the percentage of a Covered Expense for which the Plan is responsible. Coinsurance is separate from and is not a part of the Copay.

Congenital Condition: a disease or physical abnormality present at or before birth, regardless of cause.

Computer System: any computer, hardware, software, communications system, electronic device (including, but not limited to, smart phone, laptop, tablet, wearable device), server, cloud, or microcontroller including any similar system or any configuration of the aforementioned and including any associated input, output, data storage device, networking equipment or back up facility, owned or operated by the Insured or any other party.

Copay: that portion of a Covered Expense a Covered Person is required to pay out of their pocket before benefits will be paid for any remaining portion. Copay is separate from and is not a part of the Coinsurance.

Covered Accident: an unexpected occurrence directly caused by external, visible means and which:

- occurs while coverage is in force under the Policy for the Covered Person; and
- results in a Covered Injury to a Covered Person.

Covered Expense: an expense actually incurred by a Covered Person for Medically Necessary Medical Treatment which is:

- prescribed by a Physician for therapeutic management of a Covered Injury or Covered Sickness;
- not excluded by any provisions contained in the Policy; and
- not more than the Reasonable and Customary charges.

When the Covered Person utilizes the services of a Participating Provider, Covered Expense means the rate agreed upon and set between the Program Manager and provider for Medical Treatment which meets all the above standards.

Covered Injury: bodily harm resulting, directly and independently of any sickness, and which is caused by, arises out of, or results from, a Covered Accident or the sudden onset of physical trauma to the Covered Person. All injuries sustained in a single Covered Accident, including related conditions and recurring symptoms, will be considered as one Covered Injury.

Covered Person: a Covered Student. If the Participating School's application, approved by the Program Manager, includes dependent coverage, Covered Person includes the Covered Student's Covered Dependents.

Covered Sickness: an illness, disease, or condition that impairs the normal functioning of a Covered Person's mind or body and which is not the direct result of an injury or accident. All related disorders and recurrent symptoms of the same or a similar illness, disease, or condition will be considered the same Covered Sickness. A Covered Sickness includes pregnancy if conception occurs while the Covered Person is insured under the Policy.

Covered Student: an Eligible Student of a Participating School where:

- the Participating School submitted an application to sponsor coverage;
- the Program Manager accepted the Participating School's application;
- all Premium for the Eligible Student has been paid when due; and
- by virtue of all three conditions above, the Eligible Student becomes a participant of the Lewer International Student Trust (the "Trust").

For purposes of this definition, the term *Eligible Student* is defined in the Schedule of Benefits.

Custodial Care: care or service designed primarily to assist a Covered Person, whether or not totally disabled, in activities of daily living. Care which meets this definition will be deemed Custodial Care, regardless of where it is furnished or what it is called.

Cyber Act: an act (or series of related acts), threat, or hoax which:

- involves access to, processing of, use of, or operation of any Computer System; and
- is unauthorized, malicious, or criminal.

Cyber Incident:

- any error or omission, or series of related errors or omissions, involving access to, processing of, use of, or operation of any Computer System; or
- any partial or total unavailability or failure, or series of related partial or total unavailability or failures, to access, process, use, or operate any Computer System.

Deductible means the amount the Covered Person must pay out-of-pocket before benefits may be payable under the Policy.

Emergency Medical Condition: a Covered Injury or Covered Sickness that manifests itself by acute symptoms, including severe pain, of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

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

Emergency Services: covered inpatient and outpatient Medical Treatment furnished by a provider qualified to furnish the services, and that is needed to evaluate or stabilize an Emergency Medical Condition. Reimbursement for Emergency Services shall not be denied solely on the grounds that services were performed by a noncontract provider.

Experimental or Investigational:

- A drug, device, or Medical Treatment:
  - that has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication;
  - that is the subject of ongoing Phase I or Phase II clinical trials;
  - that is in the research, experimental study, or investigational arm of ongoing Phase III clinical trials;

  - that is 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
  - for which Reliable Evidence shows that the prevailing opinion among experts 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.
- A drug or device that cannot lawfully be marketed without United States Food and Drug Administration ("FDA") approval for marketing and which has not received such approval at the time the drug or device is furnished. However, a drug or device will not be considered Experimental or Investigational despite not having received FDA marketing approval for the purpose furnished if:
  - the drug or device is recognized for treatment of a particular cancer in at least one standard reference compendia;
  - or the drug is recommended for that particular type of cancer based on substantially accepted peer-reviewed medical literature.

Reliable evidence means only:

- published reports and articles in authoritative medical and scientific literature;
- written protocol(s) by the treating facility, or another facility studying substantially the same drug, device or Medical Treatment; or
- written informed consent used by the treating facility, or another facility studying substantially the same drug, device, or Medical Treatment.

We will make the determination if a drug, device, or Medical Treatment is Experimental or Investigational using the above criteria as the circumstances existed at the time the expense is incurred.

Full-Time Studies: enrollment and active participation in at least the minimum number of credit hours in which an international student must be enrolled and actively attending classes in the United States per the applicable student visa. Participation in no more than one online or television course per term will count toward fulfillment of

the full-time requirement; any online or television coursework more than one course per term will not count toward fulfilling the full-time status requirement. Home study and correspondence courses do not count toward fulfilling the full-time status requirement.

Home Country: the country where a Covered Person has their true, fixed, and permanent home and principal establishment and holds a current and valid passport.

Hospital: only such a facility that meets all of the following conditions:

- operates as a Hospital pursuant to law for the care and treatment of sick or injured individuals;
- has permanent and full-time care for bed patients;
- has a staff of one or more licensed Physicians available at all times;
- provides 24-hour a day care by Registered Nurses on duty or call;
- has surgical facilities;
- is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment, nor is any separate wing, ward or section of a Hospital used as such; and
- is not a place for long-term treatment of drug addiction or alcoholism, or for Custodial Care.

Hospital can also refer to a free-standing surgical center that meets all the following standards:

- is a licensed public or private place;
- has an organized medical staff of Physicians;
- has permanent facilities equipped and operated mainly for performing surgery and providing skilled nursing care; and
- has Registered Nurse services when a patient is in the facility.

Intensive Care Unit: a specifically designated unit of a Hospital which:

- is exclusively reserved for critically ill or injured patients requiring constant audio-visual observation, as prescribed by the attending Physician;
- provides room and board, trained and qualified personnel whose duties are primarily confined to such unit, and special equipment or supplies immediately available on a stand-by basis; and
- is segregated from the rest of the Hospital's facilities.

Intercollegiate Sports: participation in a sports program or competition (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.

Intramural Sports: participation in sports organized and played within a university, college, or local, formalized league.

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

Medically Necessary: Medical Treatment provided or prescribed by a Physician or at a Hospital that is necessary and appropriate for the diagnosis or management of a Covered Sickness or Covered Injury in accordance with generally accepted standards of medical practice in the United States at the time the Medical Treatment is provided.

When applied to a confinement, Medically Necessary means that the diagnosis or management of the symptoms or condition cannot be safely provided on an outpatient basis.

Medical Treatment shall not be considered Medically Necessary if it:

- is Experimental, Investigational, or furnished in connection with medical research;
- is provided solely for the convenience of the patient, the patient's family, Physician, Hospital, or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration, except as permitted by regulations drafted in accordance with applicable federal law; or
- involves a service, supply or drug not considered reasonable and necessary or payable by the Centers for Medicare and Medicaid and/or the National Coverage Determinations Manual.

We retain the right to determine whether a Medical Treatment is Medically Necessary.

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

Network: a compilation of health care providers, such as Physicians and Hospitals, that have agreed to accept reduced payments for Medical Treatment provided to the Covered Person. The Covered Person has discretion to visit any health care provider, regardless whether that provider is included in the Network (In-Network) or does not participate in the Network (Out-of-Network). Regardless whether the Covered Person elects to utilize an In-Network or Out-of-Network healthcare provider, the Covered Person may still incur out-of-pocket expenses.

Participating Provider: a health care provider, such as a Physician or a Hospital, that is included in the Network and has agreed to provide Medically Necessary Medical Treatment at set rates.

Participating School: the educational institution:

- that has elected to sponsor coverage for its Eligible Students under the Policy through submission of a completed application;
- whose application has been accepted by the Program Manager;
- whose Eligible Students participate in the Trust pursuant to the accepted application to sponsor coverage; and
- for which coverage has become effective and has not terminated.

Physician means a legally licensed practitioner of the healing arts who is practicing within the scope of their Physician's license while performing a particular service covered under the Policy. For the 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.

Physiotherapy: the Medical Treatment of a Covered Sickness or Covered Injury by use of physical means including, but not limited to, air, heat, light, water, electricity, or active exercise.

Policyholder: the entity to which the Policy is issued. The Policyholder is shown on the first page of the Policy.

Pre-Existing Condition: an injury or sickness for which, during the six-month period immediately preceding the Covered Person's Effective Date under the Policy, the Covered Person:

- consulted a Physician (or someone on the Covered Person's behalf consulted a Physician);
- had medicine prescribed;
- received medical care; or
- for which the Covered Person is currently receiving medical care.

Any expense associated with a pregnancy conceived prior to the Covered Person's Effective Date of Coverage will be limited to the pre-existing condition benefit coverage maximum shown in the Schedule of Benefits, if any, even if the child is born after the waiting period.

Reasonable and Customary: the most common charge for similar Medical Treatment within the Area in which the charge is incurred. The most common charge means the lesser of:

- Up to 200% of the Medicare published rate for the same or similar service or
- Any of the following:
  - the actual amount charged by the provider;
  - the negotiated rate, if any;
  - the fee often charged in the Area where the service was performed.

Recreational Sports: competitive physical activities played primarily for fun or as a pastime.

Registered Nurse or **Nurse**: a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other similar state authority. Registered Nurse does not include:

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

Sound Natural Teeth: teeth that are free of active or chronic clinical decay, have at least 50% bone support and are functional in the arch.

DEFINITIONS

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

Student Health Center: an ambulatory care facility affiliated or contracted with a Participating School that, at a minimum, maintains a staff consisting of a nurse director/nurse practitioner, staff Nurses, and 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. In the event a Participating School does not have a Student Health Center, the Participating School 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 this Policy.

Terrorism: an act or series of acts, including but not limited to the use and/or threat of force or violence, by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s), committed for political, religious, or ideological purposes, including any intention to influence any government and/or to put the public in fear for such purposes.

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

ELIGIBILITY, EFFECTIVE DATE, TERMINATION, AND EXTENDED COVERAGE PROVISIONS

Policy Effective Date

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.

Participating School's Coverage Effective Date

The insurance coverage becomes effective for the Participating School on the later of the first day of the Policy Term or the date requested on the Participating School's application and shown on the Participating School Schedule of Benefits, subject to payment of premiums due.

Eligibility

A student of the Participating School is eligible for insurance under the Policy when the student meets the definition of an Eligible Student shown in the Schedule of Benefits.

Effective Date for Eligible Students

Coverage for a Participating School's Eligible Students becomes effective:

- on the first day of the school term for which coverage is applied if the individual is an Eligible Student on the first day of the school term and enrolls in coverage within the first 30 days of the school term;
- if the student was not an Eligible Student on the first day of the school term, on the first day the individual became an Eligible Student, if the student enrolls within 30 days of becoming an Eligible Student;
- on the first day an Eligible Student suffers an involuntary loss of other coverage, if such loss occurs after the first day of the school term and the student enrolls in this Plan within 30 days of losing other coverage;
- on the first day of the next school term if the school requests enrollment more than 30 days after:
  - a student first becomes an Eligible Student or
  - an Eligible Student suffers an involuntary loss of other coverage; or
- under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

However, coverage will not become effective for any student who is not actively engaged in Full-Time Studies for at least the first 31 days of each school term, unless the student is unable to attend class due to an acute sickness or injury.

The Company maintains the right to investigate student status and attendance records to verify Policy eligibility requirements have been met and authorizes the Program Manager to do so on its behalf. If the Program Manager discovers that Policy eligibility requirements have not been met and no claims have been paid, the Company's only obligation is to refund Premium. However, We will not refund any premium if we have paid a claim on that Covered Person in the current school term.

Newborn Infants - Sick Baby Care: A newborn child of a Covered Person will automatically be entitled to coverage as if a Covered Dependent for 30 days from the moment of birth only for Covered Expenses incurred in the Hospital which are due directly to a Covered Injury or Covered Sickness which exists at birth, up to a maximum benefit of $50,000.

Termination of Coverage

Insurance under the Policy will automatically terminate for a Covered Person on the earliest of the following dates (the "Termination Date"):

1. The date the Participating School's coverage terminates under the Policy;
2. the last day of the period for which Premium has been timely paid according to Policy provisions (refer to the Premium provision);
3. the date the Covered Person is no longer eligible for coverage;
    a. the date the Covered Person is no longer eligible for coverage;
    b. For avoidance of confusion, 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 Plan 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:
        i. The Plan Participant is transferring to another educational institution;
        ii. The Plan Participant is approved for OPT and, on that basis, qualifies for continued coverage under the terms of the Policy document; or
        iii. 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.
4. the date requested by the Covered Person and approved by the Participating School in writing that is no sooner than 5 days after the date the Program Manager receives written notice. If We have paid a claim on that Covered Person during the current term, no refund of Premium will be made. If We have not paid a claim on that Covered Person during the current term, We will refund unearned Premium for the number of full months remaining in the unexpired term of coverage;
5. the date the Covered Person departs the United States for their Home Country or country of regular domicile; or
6. the date the Medical Benefit Maximum applicable to the Covered Person has been exhausted.

Extended Coverage Benefit

Benefits under the Policy are available only during the Policy Term shown on page 1 of the Policy Document, unless one of these Extended Coverage Benefits applies. Extended Coverage Benefits can provide up to 30 days of additional coverage to:

1. newly-enrolled students prior to the beginning of their very first terms of study with the Participating School; or
2. Covered Students who have completed their final terms of study in the United States and are preparing to return to their Home Country.

Extended Coverage Benefit for Newly-Enrolled Students

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

1. a newly-enrolled student must be enrolled in Full-Time Studies at the Participating School, and
2. the Participating School must have remitted all Premiums to the Program Manager.

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

1. up to 30 days prior to the first day of the student's first school term; or
2. for arriving students, the date the qualifying, newly enrolled, and arriving student arrives in the United States prior to classes; or
3. for transfer students, the date the student's prior insurance coverage through the previous educational institution terminates.

Extended Coverage Benefit for Covered Students Concluding their Studies

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

1. the Program Manager must receive a written request for Extended Coverage prior to the Termination Date of the Covered Student's coverage as defined in the Termination of Coverage Section, and
2. all Premiums must be paid.

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

1. 30 days following the Covered Student's graduation or completion of an educational program, or
2. the date the student departs the United States.

Important Information about the Extended Coverage Benefit

This Extended Coverage Benefit is subject to all other applicable policy terms, conditions, exclusions, and limits, including any applicable pre-existing condition limitation.

Extended Coverage for Short-Term Programs

In the event the Eligible Student's entire program of study is less than 60 days, the applicable Extended Coverage Benefit will be limited to seven days. All other Extended Coverage Benefit provisions will apply as indicated herein.

IMPORTANT NOTICES

The Company agrees to insure eligible international students of each accepted Participating School against losses covered under the Accident and Sickness Policy (the "Policy") subject to its provisions, exceptions, and exclusions. The persons eligible to be insureds are those described in the Eligibility section of the Policy.

This Brochure is intended to summarize the Plan; it does not contain all terms and conditions of coverage. Please refer to the Policy document for all terms and conditions. Where there is a conflict between any or all of 1) the Policy, 2) the terms of any ancillary product, and/or 3) this Brochure, the terms of the Policy shall supersede, followed by the terms of the ancillary product and then this Brochure.

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

This insurance is not subject to, and does not provide certain insurance benefits required by, PPACA. The insurance benefits are stated in the Policy and each Participating School's Schedule of Benefits.

PPACA requires U.S. citizens and certain U.S. residents to obtain PPACA-compliant insurance coverage unless they are otherwise exempt from PPACA. In certain circumstances, penalties may be imposed on U.S. citizens and residents who do not maintain PPACA compliant insurance coverage or who cease to qualify for exemption. Each Covered Person should consult a licensed, qualified attorney or tax professional to determine if PPACA's requirements apply to them.

This insurance is not a substitute for PPACA-compliant medical coverage. Lack of Minimum Essential Coverage may result in an additional payment with a Covered Person's taxes.

The Policy provides limited benefits and is not intended to cover all medical expenses. Please read it carefully. The Policy is nonparticipating.

No action at law or in equity may be brought to recover on the Policy prior to 60 days after proof of loss has been provided in writing, as required by the Policy. No such action may be brought after three years from the time written proof of loss is required to be given.

Service of Legal Process

Subject to and without limiting, expanding, superseding, modifying or waiving any of the foregoing terms, pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or their successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of a Covered Person arising out of this insurance. Such process may be submitted specifically to the Superintendent, Commissioner, or Director of Insurance of the state in which the Covered Person resides. Further, the Company hereby designates and appoints John Emmanuel, Locke Lord LLP, Brookfield Place, 200 Vessey St, 20th Floor, New York NY 10281, as its attorney-in-fact and agent for service of process to whom the said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.