

LewerMark®

# Plan Brochure

2026-2027

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## Portland Community College

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## Program Managed and Administered by:

**The Lewer Agency, Inc.** *(the "Program Manager")*

www.lewermark.com | 1(800) 821-7710

## Underwritten by:

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

UK Branch | 33 Gracechurch Street | London EC3V OBT, UK

**Policy Number:** LM-8675309-776

# IMPORTANT CONTACT INFORMATION

## LEWERMARK STUDENT ADVOCACY TEAM

For questions regarding benefits or claims status, contact:

- Toll Free: **1 (800) 821-7710** (Monday–Friday, 7:00 a.m. to 7:00 p.m. Central Time)
- Chat with us at: www.lewermark.com
- Email us at: lewermarksupport@lewer.com
- Your school webpage: www.lewermark.com/portlandcc

## 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 (800) 945-4355**

## 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

After dialing 911, 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

# 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 (800) 945-4355**

**Download the TELADOC App! www.teladoc.com**

GET IT ON Google Play

Download on the App Store

# 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**

# URGENT CARE VS. EMERGENCY ROOM

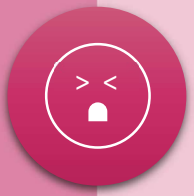
## Where should I go when I'm sick?

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**".

Type your student ID number in the space provided.

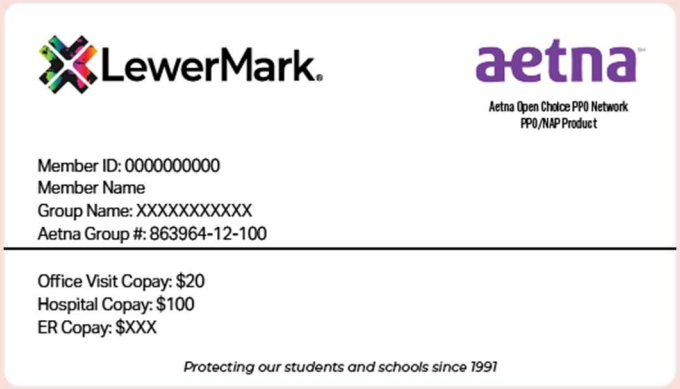
Your default password is your date of birth in order of month, day, then year. *For example, November 3, 2003, would be 11032003.*

The first time you log in, you will be asked 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. ***Tip**: Tell them you have "Aetna".*

***Front of the ID card***




***Back of the ID card***



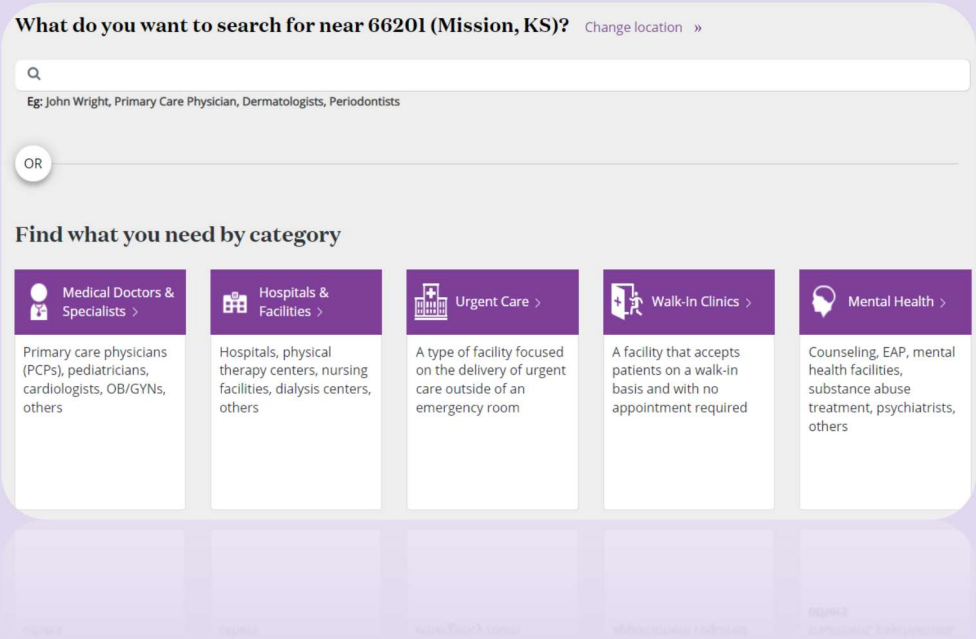

**If you have trouble logging in to your account or getting your ID card, please contact our Student Advocacy Team. You can reach us through chat at lewermark.com, by phone at 1 (800) 821–7710, or by email at lewermarksupport@lewer.com.**

# HOW TO FIND A DOCTOR

To find a doctor who is **in your network**, follow these steps:

1. Go to **www.lewermark.com**
2. Click the **"Find a Doctor"** button
3. Click **"Find an AETNA Provider"**
4. In the box that says **"Enter location here"**, type your **city or zip code**
5. Select **"Passport to Healthcare Primary PPO Network"**

If you want more options, you can also choose **"Passport to Healthcare Secondary PPO Network."**

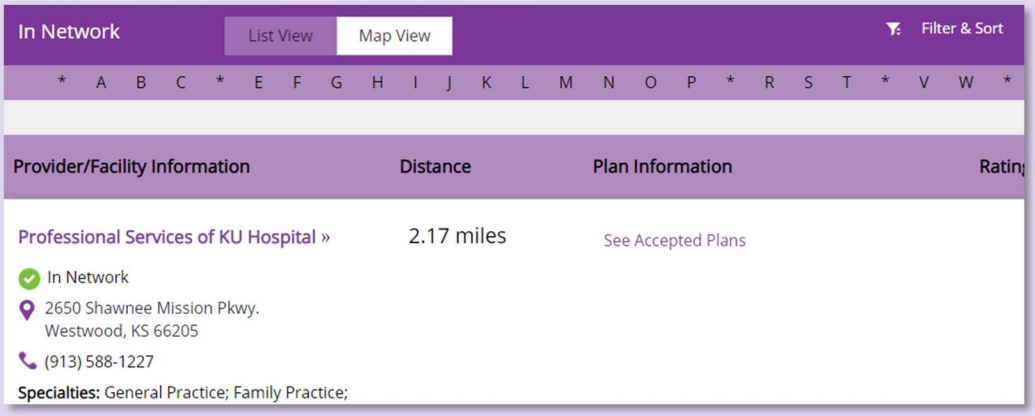



From this screen, you can see if a doctor is in-network by typing their name next to the magnifying glass.

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.*

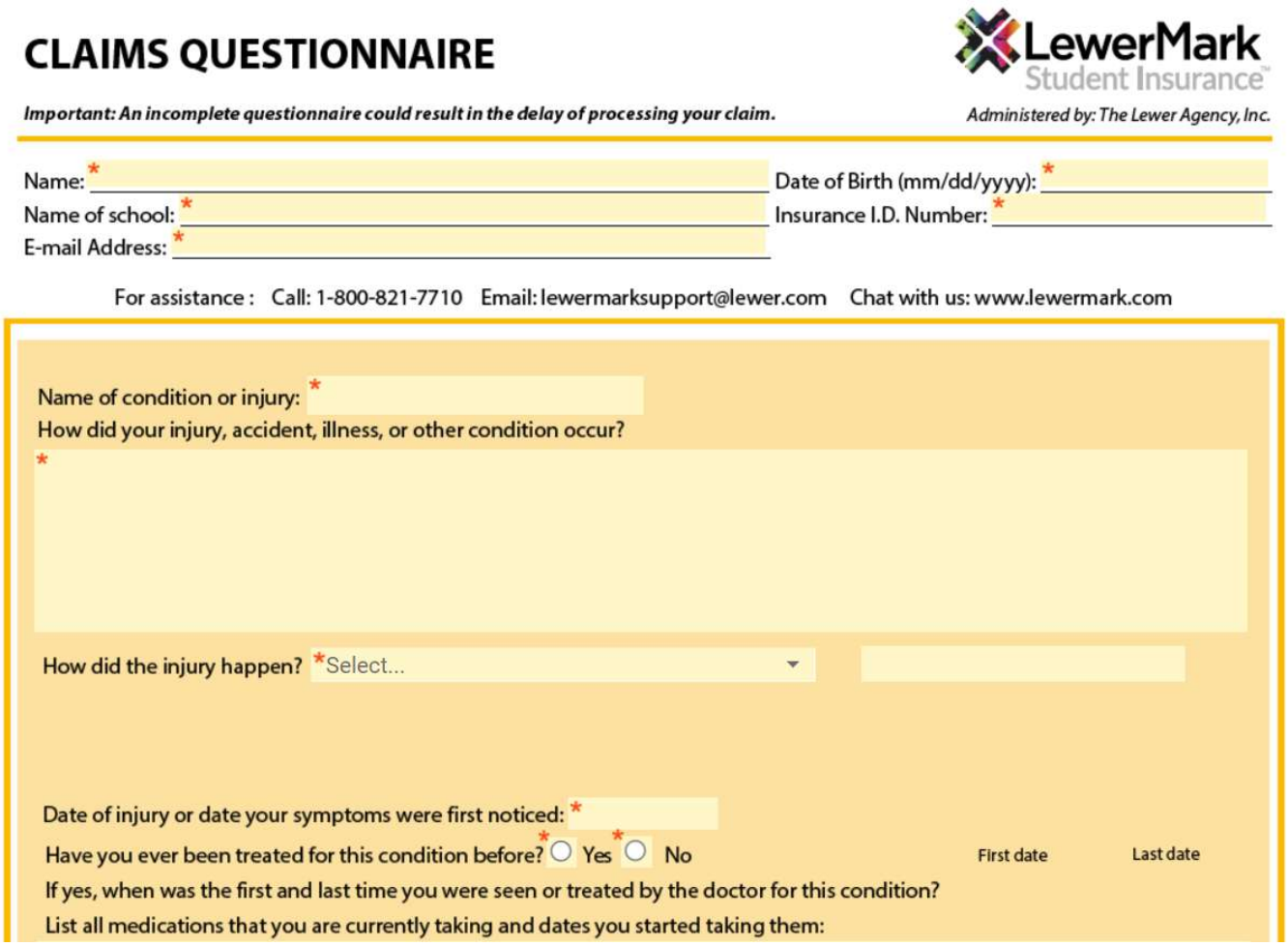
***Tip**: Call ahead to make sure the doctor is currently in-network with Aetna and to see if they are taking new patients.*




**If you need help finding a doctor or hospital, contact our Student Advocacy Team through chat on 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 claims questionnaire after you visit the doctor or go the hospital. We use the information you provide on the Claims Questionnaire to help process your claim. If you need help filling this out, please contact us!



## 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:

### 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 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 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.

# SCHEDULE OF BENEFITS

***This Policy document is intended to be read in its entirety. To understand all the conditions, exclusions, and limitations applicable to its 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 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 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:

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 Plan Participant 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 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

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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 | $5,000 |
| Pre-Existing Condition Benefit – First six months of continuous coverage<br><br>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 | $3,000 |

| 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 |

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 |
| Prescription Drug Benefit Maximum | Up to the annual maximum |
| **With respect to outpatient prescriptions, the Policy will pay the stated percentage for each 30-day supply. 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 | Not applied for/ 100% of each 30-day supply | No coverage |
| Non-Oral Prescription Contraceptives | Not applied for/ 100% at Student Health Center or 50% at other In-Network Providers | No coverage |
| 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!**

| COVERED BENEFITS | In-Network | Out-of-Network |
|---|---|---|

# SCHEDULE OF BENEFITS

| | | |
|---|---|---|
| Hospital Room and Board at Semi-Private Room Rate | 90% | 70% of URC |
| Intensive Care Unit (Average Charge) | 90% | 70% of URC |
| Urgent Care | 90% | 70% of URC |
| Outpatient Medical Care and Supplies | 90% | 70% of URC |
| Surgeon (In or Outpatient) Benefits | 90% | 70% of URC |
| Assistant Surgeon Benefit | 90% | 70% of URC |
| Anesthesia Benefit | 90% | 70% of URC |
| Pregnancy Benefits (Conception must occur while covered under the Policy) | 90% | 70% of URC |
| Diagnostic X-Ray and Labs | 90% | 70% of URC |
| Professional Ground or Air Ambulance for Emergency Services | 90% | 90% of URC |
| Infusion Therapy | 90% 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 | 90% 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% | 70% of URC |
| Medical Treatment of a Mental Condition | Inpatient – Aggregate maximum of 30 days per policy year<br>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<br>Outpatient – Aggregate maximum of 10 visits per policy year | |
| Wellness Benefit (Not subject to Copay or Deductible) | 100% up to a Maximum Benefit of $500 per policy year | |
| Inpatient Physiotherapy Expense | 90% | 70% of URC |
| Outpatient Physiotherapy Expense: Must be prescribed in writing by a Physician (20 visit maximum) | 90% | 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% | 70% of URC |
| Durable Medical Equipment Expense Benefit: Must be prescribed in writing by a Physician | 90% | 70% of URC |
| STD Testing | 90% | 70% of URC |
| **COVERED BENEFITS** | **In-Network** | **Out-of-Network** |
| Skilled Nursing Facility | 90% | 70% of URC |
| Hospice Care (14-day maximum) | 90% | 70% of URC |
| Home Country Coverage | $1,500 per policy year | |
| Club/Intramural/Recreational Sports Benefit | 90% | 70% of URC |
| Intercollegiate Sports Benefit | Not covered | |

| | |
|---|---|
| Self-Inflicted Injury | $15,000 per policy year |
| Elective Termination of Pregnancy | $1,000 Maximum Benefit |
| Emergency Dental Injury | Up to $2,500 per policy year |
| Palliative Treatment of Dental Pain | Not covered |
| Continuation Coverage | Available up to a maximum of 13 weeks or up to a Maximum Benefit of $10,000, whichever is reached first |
| Medical Evacuation | Unlimited benefit through Scholastic Emergency Services |
| Repatriation | Unlimited benefit through Scholastic Emergency Services |
| 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 Plan Participants (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

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

Accident and Sickness Medical Expense Benefits are only payable for:

1. the Preferred Allowance or Usual, Reasonable and Customary Charges incurred after the Copay has been met;
2. Medically Necessary Eligible Expenses incurred by or on behalf of a Covered Person;
3. Eligible Expenses for which the Program Manager receives an invoice within 365 days after the date of service.

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

1. **Medical Treatment**
2. **Hospital Admission Expenses**
3. **Outpatient Pre-Surgical Testing benefit:** Charges for Medically Necessary Pre-surgical testing.
4. **Nursing Services:** Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional Nurse.
5. **Skilled Nursing Facility (SNF):** Charges for SNF confinement that occurs within 14 days of a hospital discharge, where SNF care is Medically Necessary for the same condition which required hospitalization and hospitalization lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The SNF may not be primarily a place which provides general care for the aged.
6. **Hospice Care:** Charges for a maximum of 14 days of:
    a. nursing care by a Registered Nurse or any of the following who are under the direct supervision of a Registered Nurse: a Licensed Practical Nurse, Licensed Vocational Nurse, or Public Health Nurse;
    b. Physical Therapy and speech therapy when rendered by a licensed therapist;
    c. medical supplies, including drugs and the use of medical appliances;
    d. Physician's services; and
    e. services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
7. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
8. Charges for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.
9. Diabetes Coverage, including medical supplies, equipment and education for diabetes care.
10. **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.
11. **Hospital Room & Board:** We will pay the Covered Percentage of Eligible Expenses for the **Average Semiprivate Charge** for each day of the Hospital Stay. Hospital Room and Board expenses will include floor nursing while confined in Hospital and other Hospital services inclusive of charges for professional service provided, however, that expenses do not exceed the Hospital's Average Semiprivate Charge. We will not pay for personal services of a non-medical nature.
12. **Intensive Care Unit:** We will pay the Covered Percentage of Eligible Expenses for each day of Intensive Care Unit confinement. This payment will be in lieu of payment for Hospital Room and Board charges for those days and includes nursing services.
13. **Hospital Miscellaneous Expense:** We will pay for services, supplies and charges during a Hospital Stay. Eligible Expenses include: the cost of an operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services and supplies; and blood transfusions. Charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items are not Eligible Expenses.

14. **Surgeon (In or Outpatient):** We will pay the Covered Percentage of Eligible Expenses 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 shown in the Schedule of Benefits.
15. **Pre-Admission Testing:** We will pay benefits for charges for Medically Necessary Pre-admission testing.
16. **Anesthesia Benefit:** We will pay the Covered Percentage of Eligible Expenses for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure, whether on an Inpatient or Outpatient basis.
17. **Day Surgery Miscellaneous Expense:** We will pay for services and supplies incurred in connection with a covered day Surgery, such as: the cost of an operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies.
18. **Diagnostic X-Ray and Laboratory Benefit:** We will pay the Covered Percentage of Eligible Expenses for diagnostic x-ray and/or laboratory examinations and services, up to the Maximum Benefit Amount, if any, per Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the Maximum Benefit Amount, if any, shown in the Schedule of Benefits.
19. **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 Eligible Expenses, up to the Maximum Benefit Amount shown in the Schedule of Benefits, if any, for transportation within the metropolitan area in which the Covered Person is located at the 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 an Accident or Emergency to a Hospital, or between Hospitals. Surface trips must be to the closest local 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 is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care.
20. **Physician Visit Benefit (Inpatient):** We will pay the Covered Percentage of 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).
21. **Physician Visit Benefit (Outpatient):** We will pay the Covered Percentage of Eligible Expenses for Physician office visits, up to the Maximum Benefit Amount, if any, shown in the Schedule of Benefits for Physician's (Outpatient).
22. **Consultant Physician Benefit:** If, by reason of a Covered Person's Injury or Sickness, an attending Physician deems the services of a Consultant or Specialist necessary for purposes of confirming or determining a diagnosis and orders those services, We will pay the Covered Percentage of the Eligible Expenses incurred.
23. **Radiation/ Chemotherapy Therapy Expense Benefit:** We will pay the Covered Percentage of Eligible Expenses incurred by 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 patient for the treatment regimen that includes FDA approved drugs for off-label indications.
24. **Infusion Therapy:** We will pay the Covered Percentage of Eligible Expenses, up to the policy year Maximum Benefit Amount shown in the Schedule of Benefits, if any, for infusion therapy prescribed and administered by a licensed Physician.

25. **Renal Dialysis/Hemodialysis:** We will pay the Covered Percentage of Eligible Expenses, up to the policy year Maximum Benefit Amount shown in the Schedule of Benefits, if any, for Renal Dialysis/Hemodialysis prescribed and administered by a Physician.
26. **Post-Mastectomy Coverage:** 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.
27. **Emergency Room Benefit:** We will pay the Covered Percentage of Eligible Expenses if the Covered Person requires Emergency Room treatment resulting directly, and independently of all other causes, from an 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.
28. **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.
29. **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, related to Medical Treatment required as the result of an intentionally self-inflicted injury or sickness, suicide, or attempted suicide, while sane or insane.
30. **Allergy Testing and Treatment:** We will pay the Covered Percentage of Eligible Expenses for Medically Necessary testing and treatment of allergies, as diagnosed and prescribed by a Physician.
31. **Wellness Medical Expense Benefit:** We will pay for any combination of the following, up to the Wellness Benefit Maximum shown in the Schedule of Benefits: routine physical examinations 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.
32. **Maternity and Pre-Natal Care Benefit:** We will pay the Covered Percentage of Eligible Expenses for maternity and prenatal care, 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. 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 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.

    This 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; for planned childbirth deliveries at home; or the purchase or rental of a breast pump, even if prescribed by a Physician.
33. **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 an Injury or Sickness which exists at birth, up to a Maximum Benefit of $50,000.
34. **Emergency Dental Expense Benefit:** We will pay the Covered Percentage of Eligible Expense related to Medical Treatment of Sound Natural Teeth damaged as the result of a Covered Injury, up to the Maximum Benefit amount shown in the Schedule of Benefits, if any. 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 covered.

35. **Palliative Treatment of Dental Pain Benefit:** We will pay Eligible Expenses, up to the policy year Maximum Benefit amount shown in the Schedule of Benefits, related to Emergency palliative dental treatment necessary for the relief of pain of Natural Teeth.

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

37. **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 the Covered Person remains on the Participating School's I-20, for a maximum of 90 days, on an approved vacation term.

38. **Physiotherapy Expense Benefit:** We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Covered Person. We will not pay benefits in excess of the Preferred Allowance or Usual, Reasonable and Customary expense. 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 any one period of individual coverage.

    For the purpose of this section, Physiotherapy means charges for physiotherapy if:

    a. recommended by a Physician for treatment of a specific Injury or Sickness or following hospitalization; and

    b. administered by a licensed physiotherapist as an outpatient.

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

39. **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 such 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 later purchased.

    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: computers, tablets, computer applications or software used in association with communication aides; 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; sun and heat lamps; exercise devices; lifts, such as seat, chair or van lifts; customization of any vehicle, bathroom facility or residential facility; customized or motorized wheelchairs; wigs; shoe inserts; breast pumps; or items typically available without a prescription (such as compression bandages or hot/cold packs).

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

    The Prescription Drug must be dispensed for the Outpatient use by the Covered Person:

    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 Outpatient setting.

41. **Extension of Accident and Sickness Medical Benefits – Continuation Benefits:** We will pay the Covered Percentage of Eligible Expenses incurred while Hospital confined for an Injury or Sickness for which a Plan Participant has a continuing claim on the date their coverage terminates, subject to the limitations and Maximum Benefit set forth in the Schedule of Benefits. Benefits payable under this provision will terminate if a Plan Participant becomes covered under any other medical coverage for the injury or sickness for which benefits were continued. Continuation Benefits are available only to Plan Participants.

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

    a. 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 the Eligible Expenses, up to the maximum duration set forth in the Schedule of Benefits, if any, incurred for such Hospital Confinement. Such confinement must be in a licensed or certified facility, including Hospitals.

    b. Benefits for Outpatient Services: We will pay the Covered Percentage of the 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 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.

Examples of services covered under this benefit include treatment for the following:

| | | |
|---|---|---|
| Bulimia | Anorexia | Bereavement |
| Attention Deficit Disorder (ADD) | Attention Deficit Hyperactivity Disorder (ADHD) | Specific Obsessive-Compulsive Disorder |
| Obsessive Compulsive Disorders | Bipolar Affective Disorder | Major Depressive Disorder |
| Delusional Disorders | Schizophrenia | Schizoaffective disorder |
| Panic Disorders | | |

Examples of services that do not meet the criteria established by the Insurer for consideration under this benefit include:

a. Services for conditions not determined by Insurer to be emotional or personality illnesses;
b. Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
c. Services for mental disorders or illness which are not amenable to favorable modification; and
d. Family or marital counseling.

43. **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:

    a. Benefits for Inpatient Hospital Confinement: When a Covered Person is Inpatient in a Hospital or a 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. Such Confinement must be in a licensed or certified facility, including Hospitals.

    b. 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 treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency. Outpatient Treatment include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or drug or alcoholism treatment facility, so long as the Hospital, community mental health facility or drug or alcoholism treatment facility is approved by the Joint

Commission on the Accreditation of Hospitals or certified by the Department of Health.

**Alcohol Abuse** means a condition characterized by a pattern of pathological use of alcohol 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** means a condition characterized by a pattern of pathological use of a drug(s) 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 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 the appropriate addiction treatment programs for Alcohol and Drug Abuse.

44. **Emergency Medical Evacuation, Medical Repatriation and Return of Remains**

a. Medical Evacuation Benefit: Subject to prior approval from the Program Manager or its authorized representative, We will cover reasonable expenses related to 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:

i. is upon the attending Physician's written certification;
ii. results from a covered Injury or Sickness; and
iii. **does not occur prior to the benefit approval.**

b. 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.

45. **Cyber Risks Endorsement (Personal Accident & Illness):** Any benefits for Injury or Sickness caused by or arising out of a Cyber Act or a Cyber Incident are payable, subject to the terms, conditions, limitations, and exclusions of this Policy.

46. **Extended Coverage Benefit:** Benefits under this Policy are available beginning on the Effective Date and ending upon the Expiration Date. However, an Extended Coverage Benefit can provide no more than 30 days of additional coverage to certain Plan Participants, specifically to:

a. Newly enrolled students prior to beginning their very first terms of study with the Participating School, or
b. Plan Participants who have completed their final terms of study in the United States and are preparing to return to their home countries.

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 School, 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; or
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. Program Manager must receive written request for Extended Coverage prior to the Termination Date of the Plan Participant's coverage, 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 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 Policy Period limitation.

Extended Coverage for Short-Term Programs: In the event the Plan Participant'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.

# 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 in excess of benefits provided elsewhere in this coverage. 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 benefit coverage 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.
3. Medical Treatment which:
   - 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 an Immediate Family member 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.
4. Medical Treatment required for any 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;
5. Charges in excess of the Preferred Allowance or Usual, Reasonable and Customary charges, whichever applies, or to the extent the Covered Person received any discount, credit, or reduction;
6. Any of the following:
   a. 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 an Injury or covered eye Surgery;
   b. 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;
   c. Customized or motorized wheelchairs.
7. All forms of contraceptives/birth control;/Intrauterine devices (IUDs) and birth control implants, including any procedures related to the placement and/or removal of such.
8. 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; breast enlargements; correction or treatment of a deviated septum; or, cosmetic, plastic, reconstructive, or restorative surgery;
9. 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;
10. Medical Treatment related to organ or tissue transplants, whether as donor or recipient. This exclusion includes expenses incurred for the evaluation process, the 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;
11. Any charges in excess of benefits provided elsewhere in the coverage, if any, for Medical Treatment for an Injury sustained in practicing for or participating in Intercollegiate Sports;

12. 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;
13. Medical Treatment for Injury or Sickness sustained as a result of the voluntary, active participation in:
    a. Any war or any act of war, declared or undeclared; or
    b. A civil war, riot, rebellion, insurrection, or revolution.
14. Any charges in excess of benefits provided elsewhere in the coverage, if any, for Medical Treatment arising out of aeronautics or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
15. Medical Treatment for cessation or deterrence of using tobacco or nicotine;
16. Any charges 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 drugs or medication:
        - 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 or consumption 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 action or Injury;
        - A suicide or attempted suicide; or
        - Actual or attempted self-destruction.
17. Charges which exceed benefits provided elsewhere in this coverage, if any, for Medical Treatment received in connection with any of the following: dental care; orthodontia care; myofascial pain; or temporomandibular joint dysfunction;
18. Medical Treatment for Injuries sustained while:
    a. practicing for or participating in professional sports; or
    b. 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 above elevation 4500 meters above ground level or without proper equipment or guides; luge, motocross; Moto-X; ski jumping; off-piste or off-trail skiing or snowboarding; sub-aquatic activities below 50 meters; or whitewater rafting exceeding Class IV difficulty.
19. 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 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.

For purposes of this exclusion, the term motor vehicle includes any self-propelled vehicle capable of transporting a person or persons. Motor vehicle includes motorcycles, electric bikes, and electric scooters. For purposes of this exclusion, the term "law" includes regulations, ordinances, or any similar government edict, the violation of which could subject one to any penalty including but not limited to incarceration, fine, or restriction or revocation of one's drivers' license.

20. 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;
21. Any Medical Treatment received in connection with any sleep disorder, including sleep apnea machines.
22. Medical Treatment for infertility, obesity (including bariatric surgery and anorectics), acne (in excess of benefits provided elsewhere in the coverage, if any), alopecia (loss of hair), or excessive sweating (hyperhidrosis);
23. 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 and treatment);
24. Any of the following: genetic medicine, testing, or screening procedures; genetic surveillance testing; or any other procedure used to determine genetic predisposition. This exclusion applies to, but is not limited to: amniocentesis, risk assessments, preventive and prophylactic measures indicated only by genetic testing, genetic counseling, and gene therapy;
25. Medical Treatment for diagnosis and testing for or related to any learning disability;
26. Medical Treatment related to any previously known Congenital Condition, whether or not the Covered Person previously sought treatment for the condition;
27. Private-duty nursing services and Custodial Care;
28. Expenses incurred for an Injury or Sickness which occurred before the Covered Person's Effective Date or after the Expiration Date, or were incurred after the date of termination of coverage;
29. Any of the following which are in excess of benefits provided elsewhere in this coverage, if any: regular health checkups, 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, and tuberculosis tests;
30. Covered Person being exposed to the utilisation of Nuclear, Chemical or Biological Weapons of Mass Destruction, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.

# DEFINITIONS

**Unless separately defined herein, wherever used in the Policy:**

**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.

**Application** means the Policyholder's Application for inclusion under the Master Policy.

**Area** means the location where medical care or supplies are provided.

**Average Semiprivate Charge** means 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 Hospitals' lowest charge for single bedroom and board accommodations.

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

**Close Relative** means the Covered Person's Spouse, child(ren), siblings, parents, and aunts and uncles.

**Club Sports** means 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** means the percentage of Eligible Expenses for which the Plan is responsible after the Copay, Deductible, if any, has been met. Coinsurance is separate from and is not a part of the Copay.

**Company** means SiriusPoint International Insurance Corporation. Also hereinafter referred to as We, Us and Our.

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

**Computer System** means 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 includes any associated input, output, data storage device, networking equipment, or back up facility owned or operated by the Insured or any other party.

**Copay** means a specified charge that the Covered Person is required to pay when a medical service is rendered. Copay is separate from and is not part of the Coinsurance.

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

**Covered Dependent** means any dependent of a Plan Participant who meets all of the following eligibility criteria:

1. Is the Plan Participant's lawful Spouse or unmarried dependent child who is under age 19 and a full-time student (unless disabled);
2. resides with the Plan Participant;
3. is enrolled for coverage under the Policy at the same time the Plan Participant enrolls;
4. has a current passport and visa (non-domiciled United States Citizen – passport only); and
5. is temporarily outside their Home Country or country of regular domicile as a nonresident alien in the United States.

A dependent child includes a Plan Participant's natural, step, or adopted child, or a child placed for adoption. A person cannot be a Covered Person and a Covered Dependent at the same time.

A Plan Participant's dependent child who is born in the United States will be considered a dependent who may be considered eligible for coverage.

A Plan Participant's disabled, unmarried dependent child may continue to be a Covered Dependent beyond age 19 if all the following additional conditions are met:

1. The child became disabled before reaching age 19;
2. The child is incapable of self-sustaining employment because of developmental disability or physical handicap and is chiefly dependent upon the Plan Participant for support and maintenance;
3. The Plan Participant remains insured under this Policy;
4. The child's Premiums are paid on time and in full;
5. Within 30 days of the child reaching age 19, the Plan Participant furnishes a Statement of Disability to the Program Manager. Approval of such statement is required for the child to continue eligibility; and

6. The Plan Participant provides satisfactory proof to the Program Manager of the child's disability and dependent status when requested. Such proof shall be without cost to the Company or the Program Manager. The Program Manager will not ask for proof more often than once a year after the two-year period following the child's attainment of age 19.]

**Covered Loss** means an accidental death, dismemberment or other Injury covered under the Accidental Death & Dismemberment benefits of the Policy and indicated on the Schedule of Benefits.

**Covered Person** means a Plan Participant. If the Participating School's application for coverage, approved by the Program Manager, includes dependent coverage, the term Covered Person includes the Plan Participant's Covered Dependents.

**Covered Person's Effective Date** means the date on which the Plan Participant or Covered Dependent becomes entitled to coverage under the terms of this Policy.

**Custodial Care** means 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** means an act (or series of related acts), threat, or hoax which:

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

**Cyber Incident** means:

- an 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 unavailabilities 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, as set forth in the Schedule of Benefits.

**Dentist** means a legally licensed Doctor of Dental Surgery, Dental Medicine, or Dental Science. A dental hygienist who works within the scope of his/her license under the supervision of a Dentist is a covered practitioner.

**Eligible Expense(s)** means the Preferred Allowance or Usual, Reasonable and Customary charges for services or supplies incurred by the Plan Participant for Medically Necessary treatment of an Injury or Sickness. Eligible 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 Injury or Sickness must manifest itself by acute symptoms which are 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 the health of the individual, or, in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- serious impairment of bodily functions; or
- serious damage to or dysfunction of a body organ or part.

**Emergency Services** means covered inpatient or 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 noncontracted provider.

**Experimental or Investigational:**

- A drug, device, or Medical Treatment:
    - that is part of a clinical trial, experimental phase, or investigational phase;
    - that cannot be utilized without informed consent of the patient or their guardian;
    - that is the subject of ongoing Phase I or Phase II clinical trials;
    - that is 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 be lawfully marketed without approval of the Food and Drug Administration ("FDA") and for which approval for marketing has not been received at the time the drug or device is furnished;
- A drug, device, or Medical Treatment, or the patient informed consent document utilized with the drug, device or Medical Treatment, 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.

**Full-Time Studies** means 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 in excess of 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** means the country where a Covered Person has their true, fixed, and permanent home and principal establishment and holds a current and valid passport.

**Hospital** means an institution licensed, accredited, or certified by the State that:

1. operates as a Hospital pursuant to law providing Inpatient care, treatment, and services for sick or injured persons;
2. is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
3. provides 24-hour nursing service by Registered Nurses (R.N.) on duty or call;
4. has a staff of one or more licensed Physicians available at all times;
5. provides organized facilities for diagnosis, treatment, and Surgery, either
6. on its premises; or
7. in facilities available to it, on a pre-arranged basis;
8. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, nor is any separate ward, wing or section of the Hospital used as such; and
9. is not a place for long-term treatment of drug addiction, alcoholism, or Custodial Care.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Hospital does not include a place, special ward, floor or other accommodation used for custodial or educational care; home for the aged; or an institution mainly rendering treatment or services for mental illness or Substance Abuse, except as specifically stated.

**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 Plan Participant's Spouse, domestic partner, Civil Union Partner, parent (includes stepparent), child(ren) (includes legally adopted or stepchild(ren)), brother, sister, grandchild(ren), and in-laws.

**Injury** means bodily harm which:

- results independently of disease or bodily infirmity;
- is caused by an Accident that occurred after the Covered Person's Effective Date under the Policy; and
- is sustained while the Policy is in force as to the Covered Person.

All injuries a Covered Person sustains in a single Accident, including all related conditions and recurring symptoms of the injuries, will be considered one Injury.

**Inpatient** means a Covered Person who is confined in an institution and 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 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** means participation in sports organized and played within a university, college, or a local, formalized league.

**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.

**Investigational**. See Experimental.

**Maximum Benefit** means the largest total amount of Eligible Expenses the Company will pay for the Covered Person as shown in the Schedule of Benefits.

**Medical Treatment** means all medical care, treatment, services, supplies, procedures, or drugs administered to a Covered Person to address a Sickness or Injury.

**Medically Necessary** means a treatment, drug, device, service, procedure, or supply that is:

1. required, necessary, and appropriate for 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; and
4. consistent with medical and surgical practices prevailing in the Area for treatment of the condition at the time rendered.

When applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an Outpatient basis.

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 service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used; in such a situation, We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply, or service shall not be considered Medically Necessary if it:

- is Experimental, Investigational, or for research purposes;
- is provided for educational purposes or the convenience of the Covered Person or their family, Physician, Hospital or any other provider;
- exceeds in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate diagnosis or treatment;
- is ongoing treatment that is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or quality of medical care;
- involves the use of a medical device, drug, or substance not formally approved by the United States FDA;
- involves a service, supply, or drug 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 Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

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

**Mental, Behavioral, and Neurodevelopmental Disorder(s) means** any condition or disease, regardless of its cause, that was listed as a Mental Disorder in the most recent edition of the International Classification of Diseases on the date the Medical Treatment was rendered to a Covered Person.

**Natural Teeth** means the major portion of the 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.

**Outpatient** means a Covered Person who receives care for an Injury or Sickness in a Hospital or other institution, including ambulatory surgical center, convalescent/Skilled Nursing Facility, or Physician’s office, 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 for paying during a Policy Term. After the Covered Person satisfies 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 paying accumulated Deductibles (if any), Coinsurance and Copays. Penalties and amounts paid 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.

**Participating School** means the educational institution or other organization:

- that elected to sponsor coverage for its Eligible Students under the Policy through submission of a completed an application for coverage;
- whose application has been accepted by the Company;
- whose Eligible Students participate in the Lewer International Student Trust (the "Trust"); 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 Practitioner and Registered Dietician. 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.

**Physical Therapy** means any form of the following administered by a Physician: (1) physical or mechanical therapy, (2) diathermy, (3) ultra-sonic therapy, (4) heat treatment in any form, or (5) manipulation or massage.

**Plan Participant** means a person eligible for coverage as identified in the Participating School's Application, which has been accepted by the Program Manager, for whom proper Premium payment has been made when due; who, by virtue of the three conditions above, becomes a participant of the Trust; and who:

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

A person may not be covered as a Covered Dependent and a Plan Participant at the same time. For avoidance of confusion, a Plan Participant is no longer enrolled and actively engaged in Full-Time Studies upon graduation; the 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 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 this Policy; 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 this Policy.

**Policy** means this document, the Policyholder's Application, and any end endorsements, riders, or amendments that will attach during the Policy Period.

**Policy Period** means the time period between the Policy's Effective Date and 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 for which, during the 6 month period immediately prior to the Covered Person's Effective Date, the Covered Person (or an Immediate Family Member on the Covered Person's behalf):
    1. received (or was recommended to receive) a test, examination, or Medical Treatment for a condition which first manifested itself, worsened, became acute, or had symptoms which would have prompted a reasonable person to seek diagnosis, care, or treatment; or

2. took or received a prescription for drugs or medicine.

However, a condition which is treated or controlled solely through taking Prescription Drugs or medicine and which remains treated or controlled without any adjustment or change in the required prescription throughout the 6 month period before the Covered Person's Effective Date is not a Pre-Existing Condition.

Any expense associated with a Pregnancy conceived prior to the Covered Person's Effective Date under the Policy 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.

**Pregnancy** means the physical condition of being pregnant.

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

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

**Registered Nurse** means a licensed, registered professional Registered Nurse (R.N.).

**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 illness 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 being treated 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 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 toward the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

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

**Student Health Center** means an ambulatory care facility affiliated or contracted with a Participating School that, at a minimum, maintains a staff of a nurse director/nurse practitioner and/or 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 at the center. In the event a Participating School does not have a Student Health Center, the Participating School may request permission from Program Manager to designate a Walk-In Pharmacy Clinic to be treated as a Student Health Center for purposes of the Policy.

**Substance Abuse** means alcohol, drug, or chemical abuse, overuse, or dependency.

**Surgery or Surgical Procedure** means an invasive diagnostic procedure or the treatment of an 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, the Policyholder, the Participating School, or the Company.

**Usual, Reasonable and Customary (URC)** means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment 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; 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 reasonable determined by Us.

Usual, Reasonable and Customary Charges, Fees or Expenses, as used in the Policy to describe expenses, 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 explosive nuclear weapon or device;
- the emission, discharge, dispersal, release or escape of any of the following, if it is capable of causing incapacitating disablement or death amongst people or animals:
    - 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
    - any solid, liquid or gaseous chemical compound, when suitably distributed.

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

**We, Our, Us** means SiriusPoint International Insurance Corporation.

**You, Your, Yours,** means the Covered Person who meets the eligibility requirements of the Policy and whose Insurance under the Policy is in force.

# ELIGIBILITY, EFFECTIVE DATE, TERMINATION, AND EXTENDED COVERAGE PROVISIONS

**Policy Effective Date ("Effective Date")**

Company agrees to provide the Insurance benefits described in this 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 at the Participating School is eligible for Insurance under this Policy when the student meets the definition of an Eligible Student shown in the Schedule of Benefits.

**Effective Date for Plan Participants**

Provided we have received the required premium, coverage for a Participating School's Plan Participants becomes effective:

1. on the first day of the school term for which coverage is applied, if the student became an Eligible Student on the first day of the school term and applies for coverage within the first 30 days of the school term;
2. on the first day the student became an Eligible Student, if they were not an Eligible Student on the first day of the school term and enrolls within 30 days of becoming an Eligible Student;
3. 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 Eligible Student enrolls in this Plan within 30 days of losing other coverage;
4. on the first day of the next school term if enrollment was requested more than 30 days after:
    a. a student first became an Eligible Student or
    b. an Eligible Student suffered an involuntary loss of other coverage; or
5. 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 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.

Company maintains its 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 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 during the then-current school term.

**Effective Date for Dependents**

If dependent coverage is included on the Participating School's application and approved by Program Manager, and provided Premium has been received by Program Manager in accordance with the Policy provisions, the Effective Date of Coverage for the Covered Dependent of a Plan Participant will be determined in the following order:

1. the date the Plan Participant's coverage begins;
2. if a dependent child is born, adopted, or placed for adoption after the Plan Participant's coverage begins, the date of child's birth, adoption, or placement for adoption, if enrollment is made within 30 days of such event;
3. for dependents joining a Plan Participant's family through marriage or other court decree while the Plan Participant is covered under the Policy, on the first day of the first month following the date the dependent joins the Plain Participant's family;

4. if a dependent did not qualify at the time the Plan Participant was enrolled under the Policy, on the first day of the first month following the date the dependent first meets the definition of "Covered Dependent", if enrollment is made within 30 days of the date the dependent first meets the definition of Covered Dependent;
5. if at the time the Plan Participant was enrolled under the Policy the dependent had other coverage, on the first day that dependent suffers an involuntary loss of other coverage if the dependent meets the definition of Covered Dependent and enrollment is made within 30 days of loss of their other coverage;
6. on the first day of the next school term if enrollment is made more than 30 days after:
    a. the dependent meets the definition of Covered Dependent or
    b. where applicable, after the dependent meets the definition of Covered Dependent and suffers an involuntary loss of other coverage; or
7. under special circumstances, the effective date determined by the Company for all similarly situated eligible persons.

Coverage for a dependent cannot become effective prior to the Effective Date of Coverage for the Plan Participant.

**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 an Injury or Sickness which exists at birth, up to a Maximum Benefit of $50,000.

**Newborn Infants - Well Baby Care:**

A newborn child of a Covered Person who is not entitled to coverage under the "Newborn Infants – Sick Baby Care" provision above will be entitled to certain covered Well Baby Care if certain conditions are met. See the Description of Benefits for Newborn Infants – Well Baby Care for more details.

**Termination of Coverage**

Insurance under this 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. 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 Plan Participant 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 then-current school term, no refund of Premium will be made. If We have not paid a claim on that Covered Person during the then-current school 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 Maximum Benefit applicable to the Covered Person has been exhausted. See the See the Extended Coverage Benefit section for additional information.

See the Extended Coverage Benefit section for additional information.

**Breaks in Coverage**

If a Covered Person's coverage terminates for any reason, they will no longer be eligible for benefits under the Policy. If, at a later date, the student meets the Policy's eligibility requirements and again becomes a Plan Participant, they will be required to satisfy all applicable Pre-Existing Condition requirements before once again becoming eligible for benefits. For sake of clarity, a student who undergoes a break in coverage while pregnant will not be considered eligible for Pregnancy Benefits for that specific Pregnancy coverage for any expense associated with a pregnancy conceived during a break in 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.

**Scope of Coverage**

Benefits are payable under the Policy for Eligible Expenses incurred by a Covered Person for the items stated in the Schedule of Benefits. Benefits will be payable to either the Covered Person or the Service Provider for Eligible Expenses incurred outside the Covered Person's Home Country.

Under no circumstances will Company pay for charges in excess of Preferred Allowance or Usual, Reasonable and Customary charges. If a charge exceeds the Preferred Allowance or Usual, Reasonable and Customary charges, the amount by which the claim exceeds those amounts will not be recognized as an Eligible Expense. All charges will be deemed incurred on the date the services or supplies are rendered or obtained.

We will provide the benefits described in the Policy to all Covered Persons who incur an Eligible Expenses or suffers a Covered Loss which:

1. Is within the scope of the DESCRIPTION OF BENEFITS provisions; and
2. Occurs while the person is a Covered Person under the Policy.

# IMPORTANT INFORMATION

The Company agrees to insure the 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 issued 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 applies to him or her.

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 before the end of 60 days and 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 contained in this Section, 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 his 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.