DIANins

# 2021-2022

## International Student Injury and Sickness Plan

# BLUE SKY +

DIAN21BLUEPLUSSKY

Colleges and universities require international students to have health insurance plans while studying. Blue Plan offer international students an alternative to more expensive university plans – providing health insurance that meets the waiver requirements of higher education institutions. Coverage is available to all international students studying outside their home country who are enrolled and actively attending an accredited college or university.

## Benefit Highlights

- Unlimited Annual Maximum
- Comprehensive Inpatient and Outpatient Care, Emergency care, Prescription Drugs, Mental Health and Preventative care
- Worldwide direct-billing network plan, including the United HealthCare Options PPO Network in the US. There is no need to pay for your health services at the time of delivery
- The United HealthCare Options PPO Network includes healthcare providers and hospitals throughout the 50 states in the United States network
- Online claims filing at: **www.dianins.com/login**
- Plans are offered by WellAway Limited and claims are administered through PayerFusion Holdings LLC.
- Pharmacy benefits are directly billed via EHIM including maintenance and oral contraceptives

## Monthly Rates

| | Monthly rates | |
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| **Age band** | **Student** | **Spouse/Child** |
| Ages 17 - 24 | $96.09 | Spouse: N/A<br>Child: N/A |
| Ages 25 - 29 | $143.93 | |
| Ages 30 - 45 | $341.47 | |

## Eligibilities

* Minimum age 17 to Maximum age of 45, * Must be an International student enrolled in and attending a recognized higher education institute outside of their country of residence. * Students must actively attend classes. Home study, correspondence and online courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If the Company discovers that the policy eligibility requirements have not been met, its only obligation is to refund premium. * Termination of the insurance of the primary member shall also cancel all coverage for dependents. * Your eligibility date will be determined by the Insurer.

## Area of Coverage

This plan is written for the USA including Worldwide and excluding Home country.

## Preferred Provider Network – United HealthCare Options PPO Network

The Insurer maintains a Preferred Provider Network both within the United States

## Pharmacy

Prescription Drugs must be obtained from any EHIM in network pharmacy. Present your Medical Identification card to the pharmacy along with the copayment, at the time of purchase. The pharmacy will bill EHIM directly for your prescription. See the section titled, “How to File a Claim” for information on Prescription Drug Claims. A list of participating pharmacies can be viewed at **https://www.ehimrx.com/pharmacylocator.php**.

# Blue Sky +0

GENERAL FEATURES AND PLAN SPECIFICATIONS
The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.
Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.
The Deductible does not apply to the Out-of-Pocket Maximum.

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| U.S. Provider Network | United Healthcare |
| Area of Coverage | Worldwide excluding home country |
| Maximum Benefit Payable per Period of Insurance | Unlimited |
| Lifetime Maximum | Unlimited |
| Individual Deductible per Period of Insurance<br>• In-Network Provider<br>• Out-of-Network Provider<br>• Family is 2x Individual | $0 per Plan Participant(In-Network)<br>$50 per Plan Participant(Out of Network) |
| Office Visit Copayment<br>(waived at Student Health Center) | $25 |
| Urgent Care Center Copayment<br>(waived if admitted) | $50 |
| Emergency Room Copayment<br>(waived if admitted)<br>60% coinsurance In Network and 50% coinsurance Out of Network for non-emergency use | $100 per Occurrence |
| Out-of-Pocket-Maximum per Period of Insurance | $2,500 per Plan Participant/$5,000 Family<br>(excluding Deductible)<br>$10,000 per Plan Participant/$20,000 Family<br>(excluding Deductible) if an Out-of-Network Provider in the U.S. is used |
| Pre-Existing Condition Limitation<br>(12-months Lookback Period) | Student: Pre-Existing conditions are covered without a Waiting Period<br>Dependents: Pre-Existing conditions are covered after a 24-months Waiting Period |

Note: All Deductibles and Copayments will be waived when treatment is rendered at the Student Health Center. Benefits will be paid at the In-Network Coinsurance percentage, subject to Usual, Customary and Reasonable charges.

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| COVERED SERVICES AND BENEFIT LEVELS<br>Subject to Deductible, Coinsurance, Copayment, and Maximum Benefit per Period of Insurance. | WHAT THE INSURANCE PLAN COVERS<br>The following Coinsurance applies for In-Network Providers in the U.S. or for expenses incurred outside the U.S. (if available). Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used. |
| **HOSPITALIZATION AND INPATIENT BENEFITS** | |
| Accommodations including semi-private room | 90% Preferred Allowance |

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| Intensive Care/Cardiac Care | 90% Preferred Allowance |
| Inpatient Consultation by a Physician or Specialist | 90% Preferred Allowance |
| Hospital Miscellaneous Expenses | 90% Preferred Allowance |
| Pre-Admission Testing | 90% Preferred Allowance |
| Extended Care/Inpatient Rehabilitation<br>• Maximum Benefit per Period of Insurance: 45 days<br>• Must be confined to facility immediately following a hospital stay | 90% Preferred Allowance |
| **OUTPATIENT BENEFITS** | |
| Physician Visit/Consultation by Specialist<br>• $25 Copayment Physician/Specialist<br>• $50 Copayment Urgent Care Center | 90% Preferred Allowance |
| Diagnostic Testing<br>• X-Ray and Laboratory<br>• MRI, PET, and CT Scans<br>• Office visit Copayment applies when testing is done outside an office visit | 90% Preferred Allowance |
| Therapeutic Services, Physical Therapy, Chiropractic, Occupational Therapy, Vocational and Speech Therapy<br>• Maximum Benefit per Period of Insurance: 12 visits per Injury/Illness<br>• Office visit Copayment applies | 90% Preferred Allowance |
| **SURGICAL BENEFITS (INPATIENT/OUTPATIENT)** | |
| Inpatient, Outpatient or Ambulatory Surgery Includes:<br>• Surgeon's Fees<br>• Assistant Surgeon and Anesthesiologist<br>• Facility fees<br>• Laboratory tests<br>• Medications and dressings<br>• Other medical services and supplies | 90% Preferred Allowance |
| **EMERGENCIES** | |
| Emergency Room and Medical Services<br>• $100 Copayment waived, if admitted<br>• Coinsurance 60% In Network and 50% Out of Network for non-emergency use | 90% Preferred Allowance |
| Ambulance Services<br>• Emergency local ground ambulance | 90% Preferred Allowance |
| Emergency Dental<br>• Limited to accidental Injury of sound natural teeth sustained while covered<br>• Maximum Benefit per Period of Insurance: $1,000 | 90% Preferred Allowance<br>up to $250 per tooth |

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| **MATERNITY CARE** | |
| Normal delivery or Medically Necessary C-Section, prenatal, post-natal care, and complications of pregnancy | 90% Preferred Allowance |
| Elective Abortion<br>• Maximum Benefit per Period of Insurance: $1,500 | 90% Preferred Allowance |
| **OTHER BENEFITS (INPATIENT/OUTPATIENT)** | |
| Mental Health<br>• To treat a covered diagnosis<br>• Office visit Copayment applies | 90% Preferred Allowance |
| Preventive Care and Annual Exams<br>• 0-12 months: 9 visits maximum<br>• Child/Adult: Annual exams, immunizations<br>• In-Network or Student Health Center only | 100% Preferred Allowance<br>(Student Health Center payable at UCR) |
| Palliative Dental Care<br>• Sudden onset of pain<br>• Maximum Benefit per Period of Insurance: $600 | 90% Preferred Allowance |
| Homeopathic Care and Acupuncture<br>• Maximum Benefit per Period of Insurance: $500<br>• Office visit Copayment applies | 90% Preferred Allowance |
| Chemotherapy, Radiotherapy | 90% Preferred Allowance |
| Home Health Care | 90% Preferred Allowance |
| Hospice Care<br>• Inpatient Maximum Benefit per Period of Insurance: 45 Days<br>• Outpatient Maximum Benefit per Period of Insurance: $5,000 | 90% Preferred Allowance |
| Diabetic Medical Supplies<br>• Includes Insulin Pumps and associated supplies | 90% Preferred Allowance |
| Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions<br>• Office visit Copayment applies | 90% Preferred Allowance |
| Durable Medical Equipment<br>• Reimbursement of rental up to the purchase price | 90% Preferred Allowance |
| Alcohol and Substance Abuse<br>• Rehabilitative treatment only<br>• Office visit Copayment applies | 90% Preferred Allowance |
| Prescription Medications<br>• Up to 31-day supply per prescription<br>• Includes contraceptives | $10 Copayment per prescription for Tier 1: Generic<br>$40 Copayment per prescription for Tier 2: Brand |

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| Motor Vehicle Accident<br>• Injuries caused by Accident | 90% Preferred Allowance |
| Sports Activities<br>• Injuries arising from Interscholastic, Intramural, and Club sports | 90% Preferred Allowance |
| **NON-MEDICAL EXPENSE BENEFITS** | |
| Medical Evacuation and Repatriation | 100% |
| Return of Mortal Remains | 100% |
| **ACCIDENTAL DEATH AND DISMEMBERMENT** | |
| Principal Sum for Primary Plan Participant | $30,000 |
| Time Period for Loss | 90 days from the date of the covered Accident |
| **Loss of:** | **Benefit: Percentage of Principal Sum** |
| Accidental Death | 100% |
| Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes | 100% |
| Loss of One Hand and One Foot | 100% |
| Loss of One Hand or Foot and Entire Sight of One Eye | 100% |
| Loss of One Hand or Foot | 50% |
| Loss of Sight of One Eye | 50% |

# Exclusions and Limitations

The following is a partial list of examples of expenses which are not covered under the insurance plan:

- **Medical Necessity**: any charges that are not Medically Necessary or in accordance with established evidence based medicine.
- **Dental, Vision and Hearing Care:** any Services related to teeth, gums, or jaw (except for any injury to sound natural teeth); hearing aids; eyeglasses; and contact lenses.
- **Fertility and Infertility Treatments:** any Services related to fertility or infertility.
- **Pre-Existing Conditions:** Services related to a Pre-Existing Condition or a complication thereof during an applicable Waiting Period.
- **Sexual Dysfunction and Sex Change Services:** any Service or Prescription Drug for sexual dysfunction or to change the biological sexual characteristics to those of the opposite sex.

- **Podiatric Care:** any Services related to foot care, including corns, calluses, or other lesions, or trimming of nails.
- **Genetic Testing and Screening:** any genetic testing or screening and preventative prophylactic surgeries recommended by genetic testing or screening.
- **Elective and Cosmetic Surgeries, Treatments and Procedures:** any elective and/or cosmetic Services, Prescription Drugs, devices, items, products, and Supplies that are not Medically Necessary and that may only be provided for the purpose of improving, altering, enhancing, or genetically manipulating the quality of an existing condition.
- **Breast Reductions/Augmentation**: any Services related to breast reductions or augmentation, or complications related to or arising from breast implants.
- **Skin Conditions**: any Services related to acne or other treatments to enhance the appearance of the skin.
- **Sleep Studies and Disorders:** any Services or investigations for insomnia, sleeping disorders, sleep studies and other Treatments relating to sleep apnea, jet lag, fatigue, or stress or any related conditions.
- **Illegal Activities:** any Services related to Injuries or Illnesses resulting, arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.
- **Self-Inflicted Illness or Injury:** any Services related to Illnesses or Injuries, as well as their consequences, with respect to any conditions as a result of self-inflicted Illnesses or Injuries, suicide or attempted suicide, while sane or insane.
- **Experimental and/or Investigational Services:** Services, Supplies or Prescription Medications, as determined by Insurer to be Experimental and/or Investigational.
- **Sports and Activities:** any Services for Injuries or Illnesses arising from hazardous or extreme sports and activities, professional sports and activities, intercollegiate, and interscholastic sports.
- **Motor Vehicles:** any Services for Injuries or Accidents related to the operating of any type of vehicle or conveyance while under the influence of alcohol or any controlled substances including prescribed drugs for which the individual was provided a written warning against operating a vehicle or conveyance while taking it.
- **Alcohol and Substance Abuse**: any Services related to any Injuries or Illnesses caused by, contributed to or resulting from the use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by a Physician.
- **Usual, Reasonable and Customary**: Any charges in excess of Usual, Reasonable and Customary Charges for Out-of-Network Services.

***This list of examples is not complete; refer to your terms and conditions for a complete list of exclusions. Plan benefits are subject to the terms and conditions of the insurance plan.***