International Student Health Insurance

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INTERNATIONAL STUDENT PLAN SUMMARY

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance Plan. Please read the Description of Benefits sections for full details. All benefits described are subject to the definitions, exclusions and provisions.

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Insured Person's Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible and applicable Copayments, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and reimbursement level.

POLICY MAXIMUM BENEFITS	
US PROVIDER NETWORK	First Health
AREA OF COVERAGE	Worldwide excluding Home Country
MAXIMUM BENEFIT PER COVERED ILLNESS OR INJURY	$500,000
INDIVIDUAL DEDUCTIBLE PER PERIOD OF INSURANCE • In-Network Provider • Out-of-Network Provider The deductible for In-Network does not accrue towards the Out-of-Network Deductible	 $100 per Illness or Injury $100 per Illness or Injury
COPAYMENTS Copayments do not apply to the Deductible or the Out-of- Pocket-Maximum • Student Health Center Copayment • Physician/Specialist Office Visit Copayment • Hospital Copayment per Admission • Urgent Care Center Copayment • Emergency Room Copayment (waived if admitted)	 $5 per visit $50 per visit $0 per visit $50 per visit $250 per visit
OUT-OF-POCKET-MAXIMUM PER PERIOD OF INSURANCE • In-Network or Out-of-Network The Deductible, Copayments (including Prescription Medication) does not apply to the Out-of-Pocket Maximum.	 Unlimited
ACUTE ONSET OF PRE-EXISTING CONDITION	Maximum Benefit per Period of Insurance: $25,000
STUDENT HEALTH CENTER	Deductibles are waived when services are rendered at the Student Health Center. Services rendered at the Student Health Center are reimbursed at 100%

WHAT THE INSURANCE PLAN COVERS 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 60% of UCR when Out-of-Network Providers in the U.S. are used. Coinsurance outside the USA is 80% of UCR.	
HOSPITALIZATION AND INPATIENT BENEFITS	
ACCOMODATIONS INCLUDING SEMI-PRIVATE ROOM	90% UCR
INTENSIVE CARE/CARDIAC CARE	90% UCR
MENTAL HEALTH • Maximum number of days: 30 • Maximum Benefit: $10,000	90% UCR
INPATIENT CONSULTATION/VISIT BY A PHYSICIAN, OSTEOPATH OR SPECIALIST	90% UCR
DIAGNOSTIC TESTING AND HOSPITAL MISCELLANEOUS EXPENSE AND X-RAY AND LABORATORY	90% UCR
OUTPATIENT BENEFITS	
PRIMARY CARE VISIT • Maximum Benefit: 1 visit per day per specialty • Office Visit Copayment applies	90% UCR
PHYSICIAN VISIT OR CONSULTATION BY SPECIALIST • Maximum Benefit: 1 visit per day per specialty for Treatment of an Injury or Illness • Office Visit Copayment applies	90% UCR
DIAGNOSTIC TESTING • X-Ray and Laboratory • MRI, PET, and CT Scans	90% UCR

MENTAL HEALTH • Maximum Benefit per Period of Insurance: $1,000 • Office visit Copayment applies	90% UCR
SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	
INPATIENT, OUTPATIENT OR AMBULATORY SURGERY INCLUDES: • Surgeon's Fees • Assistant Surgeon or Anesthesiologist • Facility fees • Laboratory tests • Medications and dressings • Other medical services and supplies	90% UCR
EMERGENCY BENEFITS	
EMERGENCY ROOM AND MEDICAL SERVICES • Copayment waived, if admitted • Non-emergency use of the emergency room is Not Covered	90% UCR

AMBULANCE SERVICES • Emergency local ground ambulance	90% UCR
EMERGENCY DENTAL • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Period of Insurance: $500	90% UCR
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
PHYSICAL THERAPY • 1 visit per day • Maximum Benefit: $1,000	90% UCR
PRESCRIPTION MEDICATIONS • Up to 31-day supply per prescription • Includes oral contraceptives • Dispensed by Student Health Center • Out of Network is not covered	Tier 1 $20 Copayment per prescription Tier 2 $40 Copayment per prescription Tier 3 $60 Copayment per prescription
ACUTE ONSET OF PRE-EXISTING CONDITION Maximum Benefit per Period of Insurance: $25,000	90% UCR
RECREATIONAL ACTIVITIES OR AMATUER SPORTS	90% UCR

NON-MEDICAL EXPENSE BENEFITS

Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit payable per Period of Insurance or toward the Lifetime Maximum.

MEDICAL EVACUATION	90% UCR maximum benefit $50,000
MEDICAL REPATRIATION	Actual cost of roundtrip economy airfare/maximum benefit $25,000
RETURN OF MORTAL REMAINS	80% of UCR maximum benefit $25,000

ACCIDENTAL DEATH AND DISMEMBERMENT

PRINCIPAL SUM FOR PRIMARY INSURED PERSON	$50,000
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 or Foot	50%
Loss of Sight of One Eye	50%

1.0 ELIGIBILITY

1.1 Eligible Classes

Eligible Person is an individual who meets all the requirements of one of the covered Classes shown below:

A valid visa holder who is outside their Home Country and registered within a program that includes: Optional Practical Training (OPT), H1B work program, language programs/school or university, summer or winter camp, and students arriving in the United States prior to the start of the school/university session. Individuals must be a minimum of 17 years and a maximum of 45 years.

The Insurer has the right to investigate Eligibility status and attendance records to verify Eligibility requirements are met. If it is discovered the Eligibility requirements are not met, the insurance coverage will be terminated.

1.2 Persons Eligible to be an Insured Person

The Insured Person on this Plan who is an Eligible Person as identified in the Schedule of Benefits, a Non-United States Citizen travelling outside their Home Country and travelling to the United States and has their true, fixed and permanent home and principal establishment outside of the United States and holds a current and valid passport, and for whom proper Premium payment has been made when due.

Insured Persons are those persons described as an Eligible Class.

Students who are United States citizens are not eligible for coverage.

1.3 Effective and Termination Dates

The Insured Person's coverage becomes effective on the first day of the period for which premium is received and accepted, provided that the Insured Person is an Eligible Person.

The Insured Person's coverage ends on the earlier of the date that the Insured Person is no longer an Eligible Person, or the end of the period through which premium is paid. Termination of coverage for the Insured Person also terminates coverage for all insured Dependents.

If an Insured Person's return is delayed due to unforeseeable circumstances beyond their control, the insurance coverage will be extended until such trip can be completed, but no later than seven days from the original insurance coverage expiration, or if medical evacuation was necessary, upon the Insured Person's evacuation to the Home Country.

Termination of coverage of the Insured Person will be without prejudice to any claim incurred prior to the Effective Date of such termination.

Note: The minimum Period of Insurance must be the entire duration the Insured Person actively attends classes. Eligible individuals may enroll onto the Plan no earlier than 30 days prior to the start of their classes and terminate coverage no later than 30 days after classes have ended (See Extended Coverage).

1.4 Addition of a Newborn Baby or Legally Adopted Child

Born Under a Pregnancy Covered by the Maternity Benefit or Adopted as of the Date of Birth:

Newborn babies will be covered as a Dependent, for full coverage according to the terms of the Plan, regardless of medical status from the date of birth provided:

- Written notification is made to the Insurer within 31 days of the date of birth, or in the case of an adopted child, a copy of the legal adoption papers is required. The newborn child shall be accepted from the date of birth
- The newborn baby will be enrolled for the same coverage as the Insured Person.

Any request received beyond the 31-day notification period shall result in coverage only being effective from the date of notification and provisional coverage will be applied for the first 31 days of life, up to a $5,000 maximum. Coverage is not guaranteed and is subject to submission of a medical statement.

Born When an Insured Person is Not Covered by the Maternity Benefit: Newborn babies, that are born, and the Insured Person is not covered by the maternity benefit under this Plan, may be covered subject to the following:

- The Insured Person will provide written notification to the Insurer (Official Copy of Birth Certificate), and
- A Health Statement must be submitted detailing the medical history of the child,
- Coverage will become effective as of the date of notification, provided the Insurer has approved the Health Statement, Coverage is not guaranteed and is based upon the health of the newborn baby,
- Any applicable Pre-existing condition limitation will apply.

1.5 Addition of a Legally Adopted Child After the Date of Birth

A child adopted after the date of birth may be covered providing the following applies:

- The child must be younger than 19 years old, and
- The Insured Person will provide written notification to the Insurer (an official copy of the legal adoption papers is required with the notification), and
- A Health Statement must be submitted detailing the medical history of the child.

Coverage will be contingent based upon the terms and conditions of the Plan. Additionally,

- Coverage will become effective as of the date of notification, and
- Any applicable Pre-Existing Condition limitation will apply.

1.6 Extended Coverage

The Extended Coverage benefit is available to newly-enrolled students who arrive in the United States prior to the beginning of the first term of study in the United States, or Insured Persons who have completed their final term of study in the United States and are preparing to return to the Home Country. The Extended Coverage benefit provides up to 60 days of additional coverage.

Extended Coverage does not apply to Insured Persons who are continuing their studies or returning to studies in the United States whether at the same or different institutions.

Newly-Enrolled and Arriving Students

In order to be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. A newly-enrolled and arriving student must have enrolled in full-time studies at the higher education institution, and
2. All Premiums must be paid.
   Coverage under the Extended Coverage Benefit will become effective on the later of:

1. 30 days prior to the beginning of the term, or, if later,
2. On the first day the qualifying, newly-enrolled and arriving student arrives in the United States.

Students Concluding their Studies

An Insured Person may extend coverage for a maximum of 60 days while remaining in the United States following graduation or completion of an educational program. To be eligible for the Extended Coverage benefit and before any benefits will be paid:

1. The Insurer must receive the request for Extended Coverage prior to the termination of the Insured Person's coverage, and
2. All Premiums must be paid.
   Coverage under the Extended Coverage Benefit will terminate on the earlier of:

1. 60 days following the Insured Person's graduation or completion of an educational program, or
2. The date of departure from the United States.

Dependents of Insured Persons who are covered under the Extended Coverage benefit may also continue coverage under the same terms and conditions as the Insured Person.

Extended Coverage for Short-Term Programs

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

2.0 PREMIUM, CANCELLATION, AND PLAN PROVISIONS

2.1 Premium Payment

Your Premium due for coverage under this Policy must be paid in U.S. currency and is due at the time coverage is purchased. The Premium for each Policy Period must be paid as a single Premium payment.

2.2 Cancellation

The Insurer may at any time terminate an Insured Person, or modify coverage to different terms, if the Insured Person has at any time:

- Misled the Insurer by misstatement or concealment;
- Knowingly claimed benefits for any purpose other than are provided for under this Plan;
- Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Insurer's detriment;
- Failed to observe the terms and conditions of this Plan or failed to act with utmost good faith.

If the Insured Person cancels the insurance coverage after it has been issued or reinstated, the Insurer will only refund Premium on a pro rata basis if the Insured Person provides proof of other Health coverage or other valid reason for cancellation as determined by the Company or its Administrator. Premium refunds will not be considered if a claim has been filed during the Period of Insurance. A cancellation fee of $25 will be charged.

2.3 Period of Insurance

The insurance coverage term begins on the Effective Date as shown on the Medical Identification Card and ends at midnight on the date shown, but no longer than 365 days later. The coverage is not subject to guaranteed issuance or

renewal.

2.4 Duration of Coverage

Benefits are paid to the extent that an Insured Person receives any of the treatments covered under the Schedule of Benefits following the Effective Date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Insured Person, or their last date of coverage.

2.5 Compliance with the Plan Terms

The Insurer's liability to an Insured Person will be conditional upon that Insured Person complying with its terms and conditions.

2.6 Fraudulent/Unfounded Claims

If any claim is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.

2.7 Waiver of Terms or Conditions

The waiver of a term or condition by the Insurer in relation to an individual case will not prevent the Insurer from relying on such term or condition thereafter.

2.8 Denial of Liability

Neither the Insurer nor the Policyholder is responsible for the quality of care received from any institution or individual. This insurance coverage does not give the Insured Person any claim, right or cause of action against the Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

2.9 Extension of Benefits

If an Insured Person is hospital confined on the termination date of coverage, benefits will continue to be paid until the earlier of discharge from the hospital they are confined to, or until the Maximum Benefit has been paid, whichever occurs first. In no event will benefits continue beyond 30 days from the termination date of coverage.

2.10 Preferred Provider Network

The Insurer provides access to a Preferred Provider Network within the United States.

United States only:

- **In-Network Preferred Provider:** This tier consists of all Providers as well as other Preferred Providers designated by the Insurer and listed on the website. In-Network Providers have agreed to accept a Preferred Allowance as payment in full. The Medical Identification Card contains the logo for the network. Present it to the Physician or Hospital.
- **Out-of-Network Provider:** Utilizing Providers that are Out-of-Network is a more costly financial option for the Insured Person. The Insurer reimburses such Providers up to an Allowable Charge as determined by the Insurer. The Provider may bill the Insured Person the difference between the amounts reimbursed by the Insurer and the Provider's billed charge. Additionally, the Insured Person will pay a Coinsurance amount that is higher than if an In-Network Provider were used.
- **Out-of-Network Area:** When there are no network Providers located within a 30-mile radius of your local residence, charges from such Providers will be treated the same as a U.S. In-Network Preferred Provider.

The Insurer retains the right to limit or prohibit the use of Providers which significantly exceed Allowable Charges.

3.0 PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

Pre-Authorization is a process by which an Insured Person obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. During this process, the Insured may also be directed to

in-Network Providers capable of providing the appropriate level of care. Five Points Health Benefit must be contacted a minimum of 10 business days prior to a non-urgent scheduled procedure or treatment date, or within 48 hours

Seeking medical care at a Hospital emergency room is advised only if the Insured is suffering a Medical Emergency. When a Medical Emergency exists, the Five Points Health Benefit team must be contacted no later than 48 hours after seeking care. Within the United States, use of the emergency room for non-emergency services may result in higher Out- of-Pocket costs to the Insured Person.

The following services require Pre-Authorization:

- Any Hospitalization;
- Outpatient or Ambulatory Surgery;
- All Cancer Treatment (Including Chemotherapy and Radiation);
- Prescription medications in excess of $3,000 per refill; and
- Medical Evacuation/Repatriation and all other Non-Medical Expense benefits;
- Any condition, which does not meet the above criteria, but are expected to accumulate over $10,000 of medical treatment per Period of Insurance.

Failure to obtain pre-authorization will result in a 30% reduction in payment of covered expenses. Any such penalty will apply to the entire episode of care and does not apply to the Out-of-Pocket maximum. If treatment would not have been approved by the pre-authorization process, all related claims will be denied.

Pre-Authorization approval does not guarantee payment of a claim in full, as additional Copayments and Out-of-Pocket expenses may apply. Benefits payable under the Plan are still subject to Eligibility at the time charges are actually incurred, and to all other terms, limitations, and exclusions of the Plan.

In the event of an emergency that requires **medical evacuation,** you must contact Five Points Health Benefit in advance in order to approve and arrange such emergency medical air transportation and to have coverage. Five Points Health Benefit retains the right to decide the medical facility to which the Insured Person shall be transported. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. If the person chooses not to be treated at the facility and location arranged by Five Points Health Benefit, then transportation expenses shall be the responsibility of the Insured Person. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

4.0 MEDICAL EXPENSE BENEFIT DESCRIPTIONS

THE FOLLOWING PROVIDES AN EXPLANATION OF THE BENEFITS OFFERED BY THE INSURER. PLEASE REFER TO THE SCHEDULE OF BENEFITS FOR THE SPECIFIC BENEFITS COVERED UNDER THIS PLAN OF INSURANCE.

EXCESS PROVISION

No benefit under this Plan is payable for any Covered Expense incurred for Injury or Illness which is paid or payable by Other Valid and Collectible Medical Insurance except under an automobile insurance policy.
Covered Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with Plan provisions or requirements.

All benefits provided under this Plan for a covered Illness or Injury must be:

- Ordered or recommended by a licensed Health Care Provider and under the scope of the Physician's licensing;
- Medically necessary; and
- Delivered in an appropriate medical setting.

4.1 HOSPITALIZATION AND INPATIENT BENEFITS

4.1.a Accommodations

Benefits are provided for room and board, special diets, and general nursing care. All charges more than the allowable semi-private room rate are the responsibility of the Insured.

Benefits are also provided for treatment in the Intensive Care or Coronary Care Unit if it is the most appropriate place for the Insured to be treated, the care provided is an essential part of the Insureds treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury or receiving the same type of treatment.

The Insurer will pay costs if:

- Treatment is Medically Necessary for the Insured Person to be treated on an Inpatient or Daycare basis,
- The stay in the Hospital is for a medically appropriate period of time, and
- The treatment received is provided or managed by a Physician or specialist

Not Covered Under this Benefit

Inpatient Hospital Confinements primarily for purposes of receiving non-acute, long term Custodial Care, respite care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), are not eligible expenses.

Expense for items that are provided solely for personal comfort or convenience such as television, private rooms, housekeeping services, guest meals and accommodations, added charges for dietary preferences, telephone charges, and take-home supplies are not covered.

4.1.b Medical Treatment, Medicines, Laboratory, Diagnostic Tests, and Hospital Miscellaneous Expense

Ancillary expenses charged by a Hospital or ambulatory surgical center for Outpatient surgery. Miscellaneous expenses include, but are not limited to: X-ray, laboratory, in-Hospital physiotherapy, orthopedic appliances, pre-admission tests, and all other necessary charges, other than room and board, for services received during a Hospital stay.

4.1.c Inpatient Consultation/Visit by a Physician or Specialist

Benefits are provided for the reimbursement of one Physician visit per day while the Insured Person is a patient in a Hospital or Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care. If Medically Necessary, the Insurer may elect to pay more than one visit of different Physicians on the same day if the Physicians are of different specialties. The Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services.

4.2 OUTPATIENT BENEFITS

4.2.a Primary Care Visit

One (1) visit per day per specialty for Treatment of an Injury or Illness. Includes physicians, osteopaths, general or family practitioner and gynecologist when designated as the primary care physician (who provides the first contact for an individual with an undiagnosed health issue). All Services conducted at a Physician’s or Osteopath’s office and billed as an office setting or Outpatient visit setting.

4.2.b Physician Visit or Consultation by a Specialist

Benefits are provided for medical visits to a Physician or Specialist, in their office, if Medically Necessary. Benefits are limited to one visit per day per Insured Person. The Insurer may elect to pay more than one visit to different Physicians on the same day if the Physician or Specialist are of different specialties.

4.2.c Diagnostic Testing

Benefits are provided for diagnostic testing including echocardiography, ultrasound, and other specialized testing to diagnose an Illness or Injury.

4.3 SURGICAL BENEFITS

4.3.a Surgical Services

Benefits are provided for covered surgical services received in a Hospital, outpatient facility, daycare treatment facility, Physician's office, or other approved facility. Surgical services include the surgeon's fee, use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other Medically Necessary services.

4.3.b Anesthesia Services

Benefits are provided for the service of an anesthesiologist, other than the operating surgeon or assistant, who administers anesthesia for a covered surgical or obstetrical procedure.

4.4 EMERGENCY BENEFITS

4.4.a Emergency Room

Benefits are provided for a Medical Emergency when incurred in a Hospital's emergency room. The Insurer retains the right to deem a true Medical Emergency. Admission to the Hospital is not required for benefit consideration. Within the United States, use of the emergency room for non-emergency services may result in higher Out-of-Pocket costs to the Insured Person.

4.4.b Emergency Ground Ambulance Services

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care. This includes transporting the Insured Person from the scene of an Accident or Illness to a Hospital, from one Hospital to another, or from the Insured Person's home to a Hospital.

Not Covered Under this Benefit

The use of ambulance services for the convenience of the Insured Person will not be considered a covered service.

4.4.c Emergency Dental

Benefits are provided for Emergency Dental treatment and restoration of sound natural teeth required as a result of an Accident. All treatment must begin within 72 hours of the Accident.

Not Covered Under this Benefit

Routine dental treatment is not covered. Damage to teeth caused by chewing foods or a toothache, does not qualify under this benefit.

4.5 OTHER BENEFITS (INPATIENT/OUTPATIENT)

4.5.a Mental Health Benefits

Benefits are provided for both Inpatient mental health treatment in a Hospital or approved facility and for Outpatient mental health treatment. A Physician, licensed clinical psychologist, social worker, or licensed professional counselor must provide all mental health care services. Treatment must be provided for a psychiatric disease identified in the most recent edition of the International Classification of Diseases (ICD).

Not Covered Under this Benefit

Non-medical counseling services including but not limited to addictive behavior counseling, marriage and family counseling, educational counseling, aptitude testing, educational testing and services are not covered under this benefit.

4.5.b Physical Therapy

Benefits are provided for Medically Necessary therapy services rendered to an Insured Person. Services must be pursuant to a Physician's written treatment plan, which contains short- and long-term treatment goals and is provided to Insurer for review. The therapy must either: 1) Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time; and 2) Be of such a level of complexity and sophistication, and the condition of the patient must be such that the required therapy can safely and effectively be performed; or 3) Be necessary to the establishment of an effective maintenance program.

4.5.c Prescription Medications

Benefits are provided for medications which are prescribed by a Physician and which would not be available without such Prescription.

Not Covered Under this Benefit

Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, over the counter medicines, Experimental and/or Investigational medications, or supplies, even when recommended by a Physician, do not qualify as Prescription Medications. Any medication that is not scientifically or medically recognized for a specific diagnosis or that is considered as off label use, Experimental, or not generally accepted for use will not be covered, even if a Physician prescribes it.

4.5.d Acute Onset of a Pre-Existing Condition

Benefits are payable for an Acute Onset of a Pre-Existing Condition up to the maximum as stated in the Schedule of Benefits provided the condition or event: 1) occurs spontaneously and without advance warning either in the form of Physician recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent and immediate medical care; 2) occurs a minimum of 96 hours after the Effective Date of the Policy; and 3) treatment is obtained within 48 hours of the sudden and unexpected outbreak or recurrence.

Any repeat/reoccurrence within the same Period of Insurance will no longer be considered Acute Onset of a Pre-Existing Condition and will not be eligible for additional coverage. This benefit covers only one (1) Acute Onset of a Pre-Existing Condition per Period of Insurance. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the Effective Date of coverage.

4.5.e Recreational Activities or Amateur Sports Benefit

Benefits are provided for leisure sports and activities that are for relaxation or fun and do not require any special training, and do not heighten the risk of Injury or death to an individual. Covered leisure sports and activities: aerobics, jazzercise, dancing, yoga, baseball, basketball, bicycle riding, calisthenics, cycling, diving up to depths of 15 meters/50 feet, frisbee, horseback riding (trail only – no jumping, competition, dressage or racing), hiking/trekking below 3,500 meters elevation, jogging/running, roller skating, roller blading, sailing, sea kayaking/canoeing, snow skiing and snowboarding (on groomed trails only), soccer, squash, surfing/swimming, tennis, volleyball, whitewater rafting/canoeing up to and including Class 3 Level.

Not covered:

1. Any sport or activity not listed above
2. Hazardous or extreme sports or activities, professional sports or activities, Intercollegiate and Interscholastic sports
3. Accidents caused as a result of the Insured Person's Pre-Existing Condition
4. Participation in official competitions and their qualifying rounds, as well as attempts to break records
5. Any sport or activity that is in violation of any applicable laws, rules or regulations, away from prepared and marked in-bound territories/boundaries, and/or against the advice of the local authoritative body

5.0 NON-MEDICAL EXPENSE BENEFIT DESCRIPTIONS

ALL NON-MEDICAL EXPENSE BENEFITS MUST BE ARRANGED THROUGH FIVE POINTS HEALTH BENEFIT. FAILURE TO DO SO WILL RESULT IN NON-PAYMENT OF BENEFITS. PLEASE CONTACT FIVE POINTS HEALTH BENEFIT IN ADVANCE IN ORDER TO FACILITATE ADMINISTRATION OF THESE BENEFITS.

5.1 Medical Evacuation

The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.If You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness that occurs while You are covered under this Certificate, We will pay the necessary Actual Charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;
- Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;
- We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;
- No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
- Evacuation to Your Home Country terminates any further insurance coverage under this Certificate for You; and
- Transportation must be by the most direct and economical route.

5.2 Medical Repatriation:

In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place

of primary residence

6.0 ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT DESCRIPTION

The Insured Person must receive initial medical treatment within 30 days of the date of Accident. The maximum amount payable for this benefit is the Principal Sum indicated on the Schedule of Benefits. If the Insured Person incurs a covered loss, the Insurer will pay the percentage of the Principal Sum shown in the table on the Schedule of Benefits. If the Insured Person sustains more than one such loss as the result of one Accident, the Insurer will only pay one amount, the largest to what the Insured Person is entitled. Except for Accidental Death, the loss must result within 90 days of the Accident. Your coverage under the Plan must be in force.

Passive War and Terrorism is covered under the AD&D benefit.

For purposes of this benefit:

- Loss of a Hand or Foot means complete severance through or above the wrist or ankle joint.
- Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within 365 days of a Covered Accident, that continues for 6 months and is expected to continue for the remainder of the Insured Person's lifetime.
- Loss of Sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.
- Severance means the complete separation and dismemberment of the part from the body.

7.0 EXCLUSIONS AND LIMITATIONS

Sanctions Limitation Clause

Notwithstanding any other terms under this agreement, the insurer shall not provide coverage or will not make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation **(including, but not limited to: UN, EU, UK, US (OFAC) sanctions law(s)/regulation(s)).**

7.1 MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

All services and benefits described below, including expenses for medical treatment not expressly indicated in the Medical Expense Benefit section, are either excluded from coverage or limited under this Plan of Insurance.

1. **Abortion:** Any voluntarily induced termination of pregnancy and complications thereof, except if the mother's life is in danger.
2. **Alcohol and Substance Abuse:** 1) Treatment of any Illness or Injury caused by, contributed to, or resulting from voluntary use of alcohol, illegal substance abuse, drug, poison, gas or fumes, or any medication that is not taken in the dosage or for the purpose prescribed. 2) Medical expenses related to diagnosis, detoxification, counseling or other rehabilitative services unless the benefit is provided for on the Schedule of Benefits.
3. **AIDS/HIV:** Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex Syndrome (ARC), HIV positive, all secondary diseases, and all sexually transmitted diseases.
4. **Breast Reductio**n: All services and treatments.
5. **Charges Reimbursable by Another Entity:** Services, supplies, or treatment that are provided by or payment is available from: a) Workers' Compensation law, occupational disease law or similar law concerning job related conditions of any country; or; b) Another insurance company or government; or c) A government entity due to an epidemic or public emergency; d) Services provided normally without charge by the Health Services Center of the institution attended by the Insured Person, or services covered or provided by a student health fee.

6. **Cosmetic and Elective Surgery for Non-Medical Reasons:** Treatments, procedures or medications which are primarily for enhancement, improvement, or altering one's appearance, unless required due to a non-occupational Injury occurring while insured under this Plan. Medical complications arising from such treatments or procedures are also not covered.
7. **Dental Care:** a) Except for Accidental injury to sound, natural teeth b) unless pediatric dental is shown on the Schedule of Benefits.
8. **Experimental or Off-Label Services:** Services, supplies or treatments, including medications, which are deemed to be Experimental or Investigational or that is not medically recognized for a specific diagnosis.
9. **Fertility/Infertility Treatments and Birth Control:** Any services, procedure or treatment including medications used to: a) Treat infertility including In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and any variations of these procedures, and any costs associated with the preparation or storage of sperm for artificial insemination. b) Vasectomies and sterilization, and any expenses for male or female reversal of sterilization.
10. **Gender Identity Disorder:** Medical, surgical, and mental health expenses including prescription medications, and the medical complications arising from any treatments or procedures related to gender identity or gender dysphoria.
11. **Genetic Screening:** Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
12. **Hearing Care:** Hearing exams, hearing aids or devices, unless due to an Injury/Illness covered under the Plan. Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants.
13. **Home Country:** All medical charges incurred in the Insured Person's Home Country, in excess of the amount shown on the Schedule of Benefits.
14. **Illegal Activities:** Injuries or Illnesses resulting or arising from or occurring during the commission of an assault or felony.
15. **Immunizations for Travel:** Vaccines and preventive medications recommended or required for travel to specific countries
16. **Maternity:** Pregnancy or childbirth, miscarriage resulting from an accident, elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth of a dependent when dependent child of an Insured Person.
17. **Mental and Nervous Disorders:** Treatment as identified in the most recent edition of the International Classification of Diseases (ICD)
18. **Motor Vehicle:** Medical expenses; 1) Resulting from a motor vehicle Accident unless the benefit is provided for on the Schedule of Benefits; 2) If the operator of a motor vehicle is the Insured Person and does not possess a valid motor vehicle operator's license in the jurisdiction in which the motor vehicle Accident occurred, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor; 3) The operating of any type of vehicle or conveyance while under the influence of alcohol or any illegal substance, drug, poison, gas, or fumes including prescribed drugs for which the Insured was provided a written warning against operating a vehicle or conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the jurisdiction in which the Covered Loss occurred.
19. **Nasal Surgery:** Deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus surgery except for treatment of a covered Injury.
20. **Non-Medical Care:** Services related to Custodial Care, respite care, home-like care, assistance with Activities of Daily Living (ADL), or Milieu Therapy. Any Admission to a nursing home, home for the aged, long term care facility, sanitarium, spa, hydro clinic, or similar facilities. Any Admission arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.
21. **Organ Transplant:** Organ transplant and related procedures and expenses.
22. **Podiatric Care:** Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.
23. **Pre-Existing Conditions:** a) Treatment and expenses for routine care and maintenance related to Pre-Existing Conditions, unless coverage is provided for and shown on the Schedule of Benefits, b) Treatment and expenses incurred during a Waiting Period if shown on the Schedule of Benefits.
24. **Prescription Medications:** Prescription Medications, services or supplies as follows: a) Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as

specifically provided in this Plan, b) Immunization agents, except as specially provided, biological sera, blood or blood products administered on an Outpatient basis, c) Refills in excess of the number specified or dispensed after one year of the date of the prescription, d) Growth hormones, e) Medications used to treat or cure baldness or thinning hair.

25. **Preventive Care and Immunizations:** Annual exams, immunizations for travel or medical, screening tests, and other diagnostic procedures in the absence of an Illness.
26. **Self-Inflicted Illnesses, Injuries, or Exceptional Danger:** a) Treatment for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane. b.) Treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.
27. **Services for Administrative Purposes:** health check-ups, inoculations, immunizations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), *other than as provided for under the Wellness and Preventive Services benefit*.
28. **Sexual Dysfunction:** Any procedures, supplies, or medications used to treat male or female sexual enhancement or sexual dysfunction such as erectile dysfunction, premature ejaculation, and other similar conditions.
29. **Sexually Transmitted Diseases** services, supplies and medications for sexually transmitted diseases and all related conditions.
30. **Skin Conditions:** rosacea, skin tags, and any other Treatment to enhance the appearance of the skin (except for acne Prescription Medication as covered under the Outpatient Medication Program).
31. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
32. **Smoking Cessation:** Treatments and other expenses, whether or not recommended by a Physician.
33. **Sports and Hazardous Activities:** Losses resulting from a) Participation, practice, or conditioning program for any intramural, interscholastic, Intercollegiate, Club or professional sport or competition including cheerleading or travelling to/from such sport or competition as a participant; b) Skydiving, parachuting, SCUBA diving (deeper than 30 meters), mountain climbing (where ropes or guides are used), bungee jumping, skiing (off groomed trails), snowboarding (off groomed trails), racing by any animal or motor vehicle, spelunking, whitewater rafting (level 4 and higher), hang gliding, glider flying, parasailing, or flight in any kind of aircraft (except as a passenger in a regularly scheduled flight of a commercial airline), c) Power Vehicles: Expenses for Accidents or Injuries as a result of motorcycles, mopeds, scooters, ATV's, any one, two, or three wheeled motorized vehicle and/or sport watercraft such as wave runners, jet skis, or other powered devices whether the vehicle is in motion or not
34. **Vision Care:** Expenses including examinations, eye refractions, frames, lenses, contact lenses, fitting of frames or lenses, or vision correction surgery, unless the pediatric vision benefit is shown on the Schedule of Benefits.
35. **War and Terrorism:** a) Any loss sustained while participating in, or training for, or as a consequence of war (declared or not), or warlike operations; b) voluntary, active participation in a riot or insurrection; c) Terrorist activity including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity; d) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.
36. **Weight Related Treatment:** Any expense, service, or treatment for obesity, weight control, any form of food supplement, weight reduction programs, dietary counseling, or surgical procedures related to morbid or non-morbid obesity. Charges relating to complications arising from such treatments or surgical procedures are also excluded.
37. Services or treatment rendered by any person who is: a) living in the Insured Person's household, b) an Immediate Family Member of either the Insured Person or the Insured Person's spouse, or c) the Insured Person.
38. Services or treatment related to or arising from or in connection with all trips to the United States undertaken for the purpose of securing medical treatment or supplies.
39. **Services or treatment** provided in a military or veterans hospital or a hospital contracted for or operated by a national government or it's agency unless a. the services were rendered on a medical emergency basis and b. a legal liability exists for the charges made on behalf of a n Insured Person for the services given in the absence of insurance

7.2 NON-MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

The Insurer shall not be responsible for providing the following non-medical expense benefits to an Insured Person in a situation arising from or in connection with any of the following.

1. Travel costs that were neither arranged or approved in advance by the Insurer or authorized vendor or affiliate.
2. Taking part in military or police operations.
3. Insured Person's failure to properly procure or maintain visa, permits, or other documents.
4. The actual or threatened use or release of any nuclear, chemical, or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of the contributory cause.
5. Any evacuation or Repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical evacuation from a marine vessel, ship, or watercraft of any kind.
7. Medical evacuation directly or indirectly related to a natural disaster.
8. Subsequent medical evacuations for the same or related Illness, Injury, or emergency medical evacuation event regardless of location.

7.3 ACCIDENTAL DEATH AND DISMEMBERMENT EXCLUSIONS AND LIMITATIONS

The losses shown below or expenses resulting from or in connection with any of the following are excluded from coverage under this Plan.

1. **Illegal Activities:** Losses resulting or arising from or occurring during the commission of an assault or felony.
2. **Kidnap and Hijacking:** Any loss caused directly or indirectly from kidnap or wrongful detention of the Insured or hijacking of any aircraft, motor vehicle, train or waterborne vessel on which the Insured Person is travelling.
3. **Professional Sports:** Any loss sustained while participating in or training for any sport or activity performed for financial gain.
4. **Self-Inflicted Illnesses, Injuries, or Exceptional Danger:** a) Treatment for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane. b) Treatment for any loss or expense of nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with self-exposure to peril or bodily Injury, except in an endeavor to save human life.
5. **Sports and Hazardous Activities:** Losses resulting from a) Participation, practice, or conditioning program for any intramural, interscholastic, Intercollegiate, Club or professional sport or competition including cheerleading or travelling to/from such sport or competition as a participant; b) Skydiving, parachuting, SCUBA diving (deeper than 30 meters), mountain climbing (where ropes or guides are used), bungee jumping, skiing (off groomed trails), snowboarding (off groomed trails), racing by any animal or motor vehicle, spelunking, whitewater rafting (level 4 and higher), hang gliding, glider flying, parasailing, or flight in any kind of aircraft (except as a passenger in a regularly scheduled flight of a commercial airline), c) Power Vehicles: Expenses for Accidents or Injuries as a result of motorcycles, mopeds, scooters, ATV's, any one, two, or three wheeled motorized vehicle and/or sport watercraft such as wave runners, jet skis, or other powered devices whether the vehicle is in motion or not.
6. **Substance Abuse:** Any loss directly or indirectly resulting from alcohol or illegal drug abuse or other addiction, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed.
7. **War and Terrorism: a**) Any loss sustained while participating in, or training for, or as a consequence of war (declared or not), or warlike operations. b) voluntary, active participation in a riot or insurrection c) Terrorist activity including the use of armaments, the detonation of any form of explosive or nuclear devices, the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent, including the poisoning via the air or water supplies or food products and deliberate destruction of buildings and transportation. This exclusion extends to any action taken in controlling, preventing, suppressing or in any way relating to any terrorist activity. d) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

8.0 HOW TO FILE A CLAIM

Claims must be filed within **180 days** of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service Provider does not bill the Insurer directly, and when you have out-of-pocket expenses to submit for reimbursement. All claims worldwide are subject to Usual, Customary, and Reasonable charges as determined by Five Points Health Benefit and are processed in the order in which they are received. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer.

8.1 Medical Claims

Submit your claim via email. Follow up guidelines on the claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.
Claims may be submitted to the Insurer directly by the Provider or Facility. The Insurer will process the claim according to the Schedule of Benefits and Plan terms, and remit payment to the Health Care Provider. Ineligible charges or those in excess of the Allowable Charges will be the responsibility of the Insured Person.

If the Insured Person has paid the Health Care Provider, the Insured Person will submit the claim form along with the original paid receipts directly to the Insurer. Photocopies will not be accepted unless the Claim is submitted electronically. The Insurer will reimburse the Insured Person directly according to the Schedule of Benefits and Plan terms.

8.2 Submit Claims By:

Email: claims@fivepointsmecplan.com

Fax: +1.915.519.0261

Tel: +1.915.803.4198

Mail: 6006 N. Mesa Street – STE108, Coronado Tower El Paso, TX79912

8.3 Reimbursement Options

Claims reimbursements will be made by:

- Electronic Direct Deposit for the Insured Person where the receiving bank is located in the U.S.,
- Wire Transfer for the Insured Person's and overseas Providers where the receiving bank is located outside of the U.S., or
- Check sent to the Insured Person or Provider where electronic payment is not possible.

8.4 Settlement of Claims

When claims are presented to the Insurer, the Allowable Charges will be applied towards the Deductible. Once the Deductible has been satisfied, all Allowable Charges will be paid at the percentage listed on the Schedule of Benefits, up to the listed benefit maximum. Note the amount of Allowable Charges applied towards the Deductible also reduces the applicable benefit maximum by the same amount.

If the Plan has an Out-of-Pocket Maximum, once it is met the Plan will begin paying 100% of Allowable Charges for the remainder of insurance coverage, subject to the benefit maximums. The Out-of-Pocket Maximum does not apply to any expenses covered under the Prescription Medications benefit.

8.5 Status of Claims

To request the status of a claim or have a question about a reimbursement received, please submit the status request form via e-mail customer service atclaims@fivepointsmecplan.com Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

8.6 Releasing Necessary Information

It may be necessary for the Insurer to request a complete medical file on an Insured Person for the purpose of claims review or administration of the Plan. It may also be necessary to share such information with a medical or utilization review board, or a reinsurer. The release of such confidential medial information will only be with written consent of the Insured Person.

8.7 Subrogation, Reimbursement, and Assignment of Rights

Benefits paid under the Plan are paid on the condition that We are entitled to pursue subrogation and receive reimbursement for an Injury or Illness for which We have provided benefits when You have accrued a right of action against a third party for causing Injury or Illness for which i) We have paid benefits; and ii) You have received a judgement, settlement, or other compensation on the basis of that Illness or Injury. We have the right to be reimbursed whether the recovery You receive, or to which You are entitled, is made in a single payment or incrementally over time. Our reimbursement and subjugation rights extend to all amounts available to You or that You have received by judgement, settlement, or other recovery, including but not limited to benefits from policies of insurance issued to You and/or in the name of a covered family member or that otherwise insure to Your benefit. We automatically have a lien on any payment You receive or are entitled to receive from any person or entity because of a claim for which We have paid benefits. The lien may be enforced against any party who acquires funds arising out of or attributable to the claim.

Our obligation to pay benefits is always secondary to any automobile No-Fault/Personal Injury Protection or medical payments coverage. To the extent that We have paid a benefit for an amount that is payable by any automobile No-Fault/Personal Injury Protection or medical payments coverage, We shall have the right to collect any such amount from the automobile insurer.

You and any of Your legal representatives shall fully cooperate with Our efforts to recover the benefits We have paid. You must notify Us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to the Illness, Injury, or condition for which We have paid benefits. You shall do nothing to prejudice Our subrogation or recovery interests or Our ability to enforce the terms of these provisions. We have the sole authority and discretion to decide whether to pursue any right of recovery under this provision.

We are entitled to and may pursue any and all parties which may be liable to provide compensation to You for the claims at Our expense and may bring such action in Our name as Your subrogee/assignee. You agree to fully assist Us in pursuit of Our rights and subrogation if We do so by assignment.

9.0 APPEALS PROCEDURE

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

- A statement specifically requesting an Internal Appeal of the decision;
- The Insured Person's Name and ID number (from the ID card);
- The date(s) of service;
- The provider's name;
- The reason the claim should be reconsidered; and
- Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-915-803-4198 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Five Points Benefit Plans, 6006 N Mesa Street – Ste108 Coronado Tower El Paso, TX 79912

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for the review

Upon receipt of the request for a Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within three working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

- Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
- Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

- Any new or additional evidence considered by the Company in connection with the grievance; and
- Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale.

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 15 business days after receipt of the required information.

The written notice of Final Adverse Determination for the Internal Review shall include:

- The titles and qualifying credentials of the reviewers participating in the Internal Review;

- Information sufficient to identify the claim involved in the grievance, including the following:
  - The date of service;
  - The name health care provider; and
  - The claim amount;
- A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
- For an Internal Review decision that upholds the Company's original Adverse Determination:
  - The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
  - Reference to the specific Policy provisions upon which the determination is based;
  - A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
  - If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
  - If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
  - Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
- A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
- The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
- Notice of the Insured Person's right to contact the Director's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

DEFINITIONS

Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate."

Ambulance
Any conveyance designed and constructed or modified and equipped to be used, maintained, or operated to transport individuals who are sick, wounded, or otherwise incapacitated.

Ambulance Service
Transportation to or from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, when Medically Necessary.

Anesthetist
Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.
Assistant Surgeon means a Physician who assists the Surgeon who actually performs a surgical procedure.

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed

amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Brand-Name Prescription Drug
Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

Coinsurance
The percentage of the cost of a covered service that you pay after you meet your deductible

Complication of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copay
A fixed amount you pay for a covered service, usually when you receive it

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Covered Medical Expense
Medically Necessary charges for any Treatment, service, or supplies that are:

- Not in excess of the Usual and Customary Charge therefore;
- Not in excess of the charges that would have been made in the absence of this insurance;
- Not in excess of the Negotiated Charge; and
- Incurred while this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Deductible
The amount of money you pay before your insurance plan starts paying for covered services.

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Experimental/Investigative
Service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the definition of Medically Necessary/Medical Necessity.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance
A complaint that you communicate to your health insurer or plan.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitative Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

In-Network Providers
Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Inpatient Rehabilitation Facility
Licensed institution devoted to providing medical and nursing care over a prolonged period, such as during the course of the Rehabilitation phase after an acute Sickness or Injury.

Medically Necessary / Medical Necessity
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, inlcuding habilitation, and that meet accepted standards of medicine.

Mental Health Disorder
Condition or disorder associated with distress and interference with personal functioning. Mental Health Disorders must be listed as a Mental Health Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization and diagnostic criteria established by the American Psychiatric Association published as the latest edition of DSM (Diagnostic and Statistical Manual of Mental Disorders).

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.
10 Minimum Essential Coverages;

- Preventive and wellness services
- Hospitalization
- Emergency services
- Ambulatory services
- Prescription drugs
- Laboratory services
- Mental health and substance use services
- Rehabilitative services and devices
- Maternity and newborn care
- Pediatric services

Network Provider(Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

Organ Transplant
Me moving of an organ from one (1) body to another or from a donor site to another location of the person’s own body, to replace the recipient’s damaged, absent or malfunctioning organ.

Out-of-Network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Provider(Non-Preferred Provider)
A provider who doesn’t have a contract with your plan to provide services. If your plan covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider”.

Out-of-pocket Limit
The most you **could** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn’t cover. Some plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. See a detailed example.

Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Physical Therapy
Physical or mechanical therapy, Diathermy, Ultra-sonic therapy, Heat Treatment in any form or Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Preadmission Testing
Tests done in conjunction with and within 5 working days of a scheduled surgery where an operating room has been reserved before the tests are done.

Pre-authorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Room and Board
For an approved *inpatient* admission, *covered services* include *room and board*. This means your room, meals, and general nursing services while you are an *inpatient*. This includes hospital services that are furnished in an intensive care or similar unit.

Preventive Care(preventive services)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other

health problems.

Rehabilitative Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Student Health Center
On-campus facility or a designated facility by the Policyholder that provides Medical care and Treatment to sick or injured students and Nursing services. A Student Health Center/Student Infirmary does not include Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre- arranged basis or Inpatient care.

Substance Use Disorder
Physical or psychological dependency, or both, on a controlled substance or alcohol agent. Substance Use Disorders must be listed as a Substance Use Disorder in the most recent version of the International Classification of Disease Manual (ICD) published by the World Health Organization and diagnostic criteria established by the American Psychiatric Association published as the latest edition of DSM (Diagnostic and Statistical Manual of Mental Disorders).

UCR(Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Cares for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgent Crisis Center means a center licensed by the Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.

Surgeon
Physician who actually performs surgical procedures.