International
Student
Health
Insurance

DIANins

BLUE 90 CA

SPECTRUM
LIFE

This Plan Summary describes the key insurance benefits provided under the Blue 90 CA international student health insurance plan. **It is a summary only — the Policy and Schedule of Benefits contain the full definitions, benefits, limits and exclusions and will govern in the event of any conflict.**

IMPORTANT NOTICE

The Policy is issued by Spectrum Life Ltd., domiciled in St. Kitts and Nevis, and is not designed to cover U.S. citizens or residents. It is a non-renewable one-year term policy.

This insurance is not subject to, and does not provide certain insurance benefits required by, the U.S. Patient Protection and Affordable Care Act ("PPACA"). It is governed by the laws of St. Kitts and Nevis and subject to the exclusive jurisdiction of the courts of St. Kitts and Nevis.

Who Is Eligible to Enroll

The Insured Person is a non-U.S. citizen traveling outside their Home Country to the United States, who holds a current and valid passport and for whom premium has been paid when due. Students who are U.S. citizens or permanent legal residents are not eligible.

- **Class 1:** International students (F-1, J-1, M-1 visa) officially enrolled full-time in an accredited higher-education institution (associate, bachelor's, master's or doctoral program), ages 17–45.
- **Class 2:** The spouse of a Class 1 Insured Person.
- **Class 3:** The dependent child(ren) of a Class 1 Insured Person.

Not eligible: students taking distance learning or home study, OPT students, and U.S. citizens or residents. Eligible dependents: spouse or domestic partner up to age 64; unmarried dependent children up to age 19.

Coverage Dates and Plan Cost

An Eligible Student must actively attend classes for at least the first 90 days of the coverage period. Coverage may begin no earlier than 30 days before classes start and end no later than 30 days after classes end. Annual premium (paid as a single payment, in U.S. currency) by age band:

Age Band	Annual Premium (Blue 90 CA)
17–24 years	$1,568
25–29 years	$2,190
30–45 years	$4,863

Schedule of Benefits — Plan Highlights

POLICY MAXIMUM BENEFITS	
U.S. Provider Network	Aetna
Area of Coverage	Worldwide, excluding Home Country
Maximum Benefit per Covered Illness or Injury	Unlimited
Lifetime Benefit	Unlimited
Individual Deductible per Period of Insurance — In-Network Provider — Out-of-Network Provider — In-Network deductible does not accrue toward the Out-of-Network deductible	$100 per Insured Person (In-Network) $500 per Insured Person (Out-of-Network)

COPAYMENTS (apply toward the Out-of-Pocket Maximum)	
Student Health Center	$0 per visit

Physician / Specialist Office Visit	**$25 per visit**
Hospital (per Admission)	**$0 per visit**
Urgent Care Center	**$50 per visit**
Emergency Room (waived if admitted)	**$150 per visit**

OUT-OF-POCKET MAXIMUM & OTHER PROVISIONS	
Out-of-Pocket Maximum per Insured Person — Copayments, deductibles and coinsurance apply toward the Out-of-Pocket Maximum	**$7,000 In-Network** **$14,000 Out-of-Network**
Pre-Existing Condition Limitation	**Students and Dependents: covered with no waiting period**
Student Health Center	**Deductibles and Copayments waived; services reimbursed at 100%**

WHAT THE INSURANCE PLAN COVERS

The following coinsurance applies for In-Network providers in the U.S., or for eligible expenses incurred outside the U.S. Coinsurance reduces to 70% of UCR when Out-of-Network providers in the U.S. are used. Coinsurance outside the USA (excluding M-1/M-2 visa holders) is 90% of UCR.

HOSPITALIZATION AND INPATIENT BENEFITS	
Accommodations including semi-private room	**90% Preferred Allowance**
Intensive Care / Cardiac Care	**90% Preferred Allowance**
Inpatient consultation/visit by a physician, osteopath or specialist	**90% Preferred Allowance**
Diagnostic testing, hospital miscellaneous expense, X-ray and laboratory	**90% Preferred Allowance**
Pre-admission testing — Within 3–5 working days prior to admission	**90% Preferred Allowance**
Inpatient rehabilitation — Max 45 days per Period of Insurance — Must immediately follow a hospital stay	**90% Preferred Allowance**

OUTPATIENT BENEFITS	
Primary care visit — Office-visit copayment applies — Max 1 visit per day per specialty	**90% Preferred Allowance**
Physician visit or consultation by specialist — Office-visit / urgent-care copayment applies — Max 1 visit per day per specialty for treatment of an injury or illness	**90% Preferred Allowance**
Diagnostic testing — X-ray and laboratory; MRI, PET and CT scans — Office-visit copayment applies when done outside an office visit	**90% Preferred Allowance**
Therapeutic services — Max 12 visits per covered illness or injury, 1 per day — Office-visit copayment applies	**90% Preferred Allowance**

SURGICAL BENEFITS (INPATIENT / OUTPATIENT)	
Inpatient, outpatient or ambulatory surgery – Surgeon's fees; assistant surgeon or anesthesiologist – Facility fees; laboratory tests; medications and dressings – Other medical services and supplies	**90% Preferred Allowance**
Reconstructive surgery – Required due to a medically necessary, non-cosmetic condition, to restore or improve function – Must be performed within 12 months of the illness, injury or accident	**90% Preferred Allowance**

EMERGENCY BENEFITS	
Emergency room and medical services – Copayment waived if admitted – Non-emergency ER use reduced to 30% coinsurance In-Network / 20% Out-of-Network	**90% Preferred Allowance**
Ambulance services – Emergency local ground ambulance	**90% Preferred Allowance**
Emergency dental – Accidental injury to sound natural teeth while covered – Max $250 per tooth; $1,000 per Period of Insurance	**90% Preferred Allowance**
Palliative dental care – Sudden onset of pain – Max $600 per Period of Insurance	**90% Preferred Allowance**

MATERNITY CARE	
Normal delivery or medically necessary C-section; pre-natal, post-natal care and complications of pregnancy – Conception must occur ≥10 months after Effective Date – Services by an In-Network provider; subject to pre-authorization – Notification within 30 days of pregnancy confirmation	**90% Preferred Allowance**
Elective abortion – Max $1,500 per Period of Insurance	**90% Preferred Allowance**

OTHER BENEFITS (INPATIENT / OUTPATIENT)	
Mental health – Outpatient – office-visit copayment applies	**90% Preferred Allowance**
Preventive care and annual exams – Newborn–12 months: 9 visits max; child/adult annual exams, immunizations – In-Network or Student Health Center only; deductible does not apply – No benefits if an Out-of-Network provider is used	**100% Preferred Allowance** **Student Health Center payable at 100% UCR**
Titers – Titers benefit related to immunization for the Polio virus immune status, Hepatitis B surface AB, Hep B, Hep A, Varicella-Zoster AB, IgG, MMR, Tdap, and Rubella	**100% Preferred Allowance**

Tuberculosis screening and testing — TB screening and testing, if not covered under the Preventive Care Services — If covered by the Student Health Fee, payment will be denied — Only allowed at the Student Health Center	**100% Preferred Allowance**
Alternative medicine (chiropractic, homeopathic care, acupuncture) — Max $500 per Period of Insurance; office-visit copayment applies	**90% Preferred Allowance**
Cancer care and oncology	**90% Preferred Allowance**
Home health care — Min 3-day hospital stay; must begin within 3 days of that stay	**90% Preferred Allowance**
Hospice care — Inpatient max 45 days; outpatient max $5,000 per Period of Insurance	**90% Preferred Allowance**
AIDS / HIV+ / ARC and related conditions	**90% Preferred Allowance**
Durable medical equipment — Rental reimbursed up to the purchase price	**90% UCR**
Alcohol and substance abuse — Rehabilitative treatment only	**90% Preferred Allowance**
Prescription medications — Up to 31-day supply; includes oral contraceptives — Global Reach Rx network pharmacy required; Out-of-Network not covered	**Tier 1: $10 copay** **Tier 2: $30 copay** **Tier 3: $50 copay**
Recreational activities or amateur sports	**90% Preferred Allowance**

NON-MEDICAL EXPENSE BENEFITS (do not accumulate toward the medical maximum)	
Medical evacuation	**100% of actual costs**
Medical repatriation	**Actual cost of round-trip economy airfare**
Return of mortal remains	**100% of actual costs**

ACCIDENTAL DEATH AND DISMEMBERMENT	
Principal Sum for primary Insured Person	**$30,000**
Time period for loss	**90 days from date of covered Accident**
Accidental death	**100% of Principal Sum**
Loss of both hands or feet, or entire sight of both eyes	**100% of Principal Sum**
Loss of one hand or foot	**50% of Principal Sum**
Loss of sight of one eye	**50% of Principal Sum**

Preventive Care

Preventive care includes screenings, check-ups and counseling used to prevent illness or detect it early. Adult wellness visit and preventive services include routine measurements and history review, plus:

- Immunizations and vaccinations (Diphtheria, Hepatitis A & B, Herpes Zoster, HPV, Influenza, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella, COVID-19) — obtained at the Student Health Center or a Global Reach Rx In-Network pharmacy.

- Preventive screenings (1 per year): PAP; mammogram (age 40+); PSA test (age 50+).
- Well-child visits (children 0–12 months, 9 visits max per policy period).

Prescription Drugs

Medications filled at a Global Reach Rx network pharmacy for which a physician's written prescription is required. Drugs are grouped into tiers — Tier 1 (Generic), Tier 2 (Brand) and Tier 3 (Non-preferred brand). Some drugs are subject to pre-authorization; pre-authorization is required for prescriptions in excess of $3,000 per refill.

- **Tier 1 (Generic):** $10 copayment per prescription
- **Tier 2 (Brand):** $30 copayment per prescription
- **Tier 3 (Non-preferred brand):** $50 copayment per prescription

Provider Network & Pre-Authorization

The plan provides access to the Aetna Preferred Provider Network within the United States. In-Network providers accept a Preferred Allowance as payment in full. Using Out-of-Network providers is more costly: reimbursement is limited to Usual, Customary & Reasonable (UCR) charges and the provider may balance-bill the difference. Where no network provider is located within a 30-mile radius, charges are treated as In-Network.

Pre-authorization is required for hospitalization; outpatient or ambulatory surgery; all cancer treatment (including chemotherapy and radiation); prescriptions over $3,000 per refill; medical evacuation/repatriation and other non-medical benefits; and any condition expected to exceed $10,000 of treatment per Period of Insurance. Contact Redbridge at least 10 business days before a non-urgent procedure, or within 48 hours of an emergency admission. Failure to obtain pre-authorization results in a 30% reduction of covered expenses.

Key Exclusions and Limitations

The following are examples of services excluded or limited under the plan. This is a summary — refer to the Policy for the complete list of exclusions.

- Alcohol and substance abuse, except rehabilitative treatment shown on the Schedule of Benefits.
- Breast reduction; cosmetic and elective surgery for non-medical reasons.
- Charges reimbursable by another entity (Workers' Compensation, another insurer/government, or the student health fee).
- Dental care, except accidental injury to sound natural teeth or where pediatric dental is shown.
- Experimental, investigational or off-label services.
- Fertility / infertility treatments and birth control (IVF, GIFT, ZIFT, sterilization and reversals).
- Gender identity disorder and related treatments.
- Genetic screening absent symptoms or proven risk factors.
- Hearing care (exams, aids) unless due to a covered injury/illness.
- Home Country medical charges in excess of the Schedule amount.
- Injuries/illnesses from illegal activities; immunizations for travel.
- Motor-vehicle expenses (with stated exceptions); nasal surgery except for covered injury.
- Non-medical / custodial care; organ transplant; routine podiatric care.
- Pre-existing conditions (dependents), routine care and maintenance, except as shown.
- Sexual dysfunction; smoking cessation; sleep studies; cosmetic skin conditions.
- Hazardous / extreme sports and intercollegiate, interscholastic, intramural and club sports.
- Vision care (exams, refractions, lenses, corrective surgery) unless pediatric vision is shown.
- War and terrorism; nuclear, chemical or biological exposure.
- Weight-related treatment and obesity surgery.
- Services rendered by a family/household member; trips to the U.S. to obtain medical treatment.

Important Terms

Allowable Charge — The Reasonable and Customary charge the Insurer determines for covered services. In the U.S., when a Preferred Provider delivers the service, no balance is due.

Coinsurance — The percentage of Allowable Charges the Insured Person and Insurer share after the Deductible is met.

Copayment — A fixed dollar amount paid per office visit; applies toward the Out-of-Pocket Maximum.

Deductible — Covered Allowable Charges the Insured Person pays each Policy Period before benefits are activated; applies toward the Out-of-Pocket Maximum.

Home Country — The country from which the Insured Person holds a passport.

Medical Emergency — A sudden, unexpected event from an illness or injury that a prudent layperson would expect to place health in serious jeopardy without immediate care.

Out-of-Pocket Maximum — The maximum Allowable Charges the Insured Person pays during the Policy Year after the Deductible; thereafter the Insurer pays 100% of eligible Covered Expenses.

Preferred Allowance — The amount an In-Network provider accepts as payment in full for covered expenses.

UCR (Usual, Customary & Reasonable) — The lower of the provider's usual charge or the general rate charged by others in the same area for comparable services.

Claims & Contact

Claims are administered by Redbridge and must be filed within 180 days of treatment. Providers may bill the Insurer directly; otherwise submit a claim form with paid receipts. Reimbursement is by direct deposit (U.S. banks), wire transfer (overseas) or check.

REDBRIDGE — PLAN ADMINISTRATOR	
Claims	**claimsmiami@redbridge.cc**
Customer Service	**amgroup@redbridge.cc**
Pre-Authorization	**service@redbridge.cc**
Telephone	**305-709-0561 · Toll-free 1-800-791-4531**

This document is a summary prepared by DIANins (Plan Marketer) and does not amend the Policy. The Policy and Schedule of Benefits issued by Spectrum Life Ltd. govern all coverage. ***Plan Code 26BLUE90CA.***