International Student Health Insurance

BLUE 100

Five Points Student Health Insurance

Marketed by:

DIAN Insurance

Eligibility

The Policy covers students and their eligible Dependents who have met the Policy's eligibility requirements (as shown below) and who:

- Are properly enrolled in the Plan, and
- Pay the required premium

An Eligible Student must attend classes for at least the first 90 days of the period for which he or she is enrolled and/or pursuant to his or her Visa requirements for the period for which coverage is elected.

Except in the case of the both waiver denial and withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If We discover that the Certificate eligibility requirements have not been met, our only obligation is refund of Premium less any claims paid. Eligibility requirements must be met each time Premium is paid to continue coverage.

If the Insured Student or the Insured Student's Dependent has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during their enrollment under this insurance plan in order to obtain coverage for a service, coverage will be terminated immediately upon written notice of termination delivered by Us to the Insured Student and/or the Insured Student's Dependent, as applicable. If termination is a result of the Insured Student's action, coverage will terminate for the Insured Student and the Insured Student's Dependents. If termination is a result of the Insured Student's Dependent's action, coverage will terminate for the Insured Student's Dependent.

1. Who is Eligible
   - Class 1: All registered full time international student who taking 12 credit and full-time graduate students who taking 6 credits minimally.
     * Citizen or permanent resident students are not allowed to enroll *
   - Class 2: The Spouse of a Class 1 Insured Person
   - Class 3: The dependents child(ren) of a Class 1 Insured Person

2. Who is not Eligible
   Students taking distance learning, home study or OPT students

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 LIFETIME BENEFIT	Unlimited

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	$0 per Insured Person $200 per Insured Person
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)	 $0 per visit $25 per visit $0 per visit $50 per visit $150 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.	 $5,000 per Insured Person In-Network Unlimited - Out-of-Network
PRE-EXISTING CONDITION LIMITATION (12 months Lookback Period)	Student: Pre-Existing Conditions are covered without a Waiting Period Dependents: Pre-existing Conditions are covered after a 12 month Waiting Period
STUDENT HEALTH CENTER	Deductibles and Copayments 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 80% of UCR when Out-of-Network Providers in the U.S. are used. Coinsurance outside the USA, excluding M1/M2 visa holders is 100% of UCR.	
HOSPITALIZATION AND INPATIENT BENEFITS	
ACCOMODATIONS INCLUDING SEMI-PRIVATE ROOM	100% Preferred Allowance
INTENSIVE CARE/CARDIAC CARE	100% Preferred Allowance
INPATIENT CONSULTATION/VISIT BY A PHYSICIAN, OSTEOPATH OR SPECIALIST	100% Preferred Allowance
DIAGNOSTIC TESTING AND HOSPITAL MISCELLANEOUS EXPENSE AND X-RAY AND LABORATORY	100% Preferred Allowance
PRE-ADMISSION TESTING • Within 3-5 working days prior to admission	100% Preferred Allowance
INPATIENT REHABILITATION • Maximum Benefit per Period of Insurance: 45 days • Must be confined to facility immediately following a hospital stay	100% Preferred Allowance
OUTPATIENT BENEFITS	
PRIMARY CARE VISIT	100% Preferred Allowance

• Office visit Copayment applies • Maximum Benefit: 1 visit per day per specialty	
PHYSICIAN VISIT OR CONSULTATION BY SPECIALIST • Office visit Copayment applies • Urgent Care Copayment applies • Maximum Benefit: 1 visit per day per specialty for Treatment of an Injury or Illness	100% Preferred Allowance
DIAGNOSTIC TESTING • X-Ray and Laboratory • MRI, PET, and CT Scans • Office visit Copayment applies when testing is done outside an office visit	100% Preferred Allowance
THERAPEUTIC SERVICES • Maximum Benefit per covered Illness or Injury: 12 visits, 1 visit per day • Office visit Copayment applies	100% Preferred Allowance
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% Preferred Allowance
RECONSTRUCTIVE SURGERY • Reconstructive surgery is required as a result of Medically Necessary, non-cosmetic medical condition, to restore or improve function • Must be performed within twelve (12) months from the date of the Illness, Injury or Accident	90% Preferred Allowance
EMERGENCY BENEFITS	
EMERGENCY ROOM AND MEDICAL SERVICES • Copayment waived, if admitted • Non-emergency use of the emergency room is reduced to 40% Coinsurance In Network and 30% Out of Network	100% Preferred Allowance
AMBULANCE SERVICES • Emergency local ground ambulance	100% Preferred Allowance
EMERGENCY DENTAL • Limited to accidental Injury of sound natural teeth sustained while covered • Maximum Benefit per Tooth $250 • Maximum Benefit per Period of Insurance: $1,000	100% Preferred Allowance
PALLIATIVE DENTAL CARE • Sudden onset of pain • Maximum Benefit per Period of Insurance: $600	100% Preferred Allowance

MATERNITY CARE	
NORMAL DELIVERY OR MEDICALLY NECESSARY C-SECTION, PRE-NATAL, POST-NATAL CARE, AND COMPLICATIONS OF PREGNANCY • Dependent Spouse: Conception must occur at least ten (10) months after Effective Date • Services must be rendered by an In-Network Physician or In-Network Provider. • Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider • This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Plan Administrator will determine coverage upon receipt of the Pre-Authorization request.	100% Preferred Allowance
ELECTIVE ABORTION • Maximum Benefit per Period of Insurance: $1,500	100% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
MENTAL HEALTH Outpatient - Office visit Copayment applies	100% Preferred Allowance
PREVENTATIVE CARE AND ANNUAL EXAMS • Newborn to 12 months: 9 visit maximum per Period of Insurance • 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
ALTERNATIVE MEDICINE (CHIROPRACTIC, HOMEOPATHIC CARE AND ACUPUNCTURE) • Maximum Benefit per Period of Insurance: $1,000 • Office visit Copayment applies	100% Preferred Allowance
CANCER CARE AND ONCOLOGY	100% Preferred Allowance
HOME HEALTH CARE • Minimum Hospital Stay: 3 consecutive days • Home Health Care must begin within: 3 consecutive days after the Minimum Hospital Stay	100% Preferred Allowance
HOSPICE CARE • Inpatient Maximum Benefit per Period of Insurance: 45 Days • Outpatient Maximum Benefit per Period of Insurance: $5,000	100% Preferred Allowance
AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	100% Preferred Allowance
DURABLE MEDICAL EQUIPMENT • Reimbursement of rental up to the purchase price	100% UCR
ALCOHOL AND SUBSTANCE ABUSE • Rehabilitative treatment only	100% Preferred Allowance

PRESCRIPTION MEDICATIONS • Up to 31-day supply per prescription • Includes oral contraceptives • OPTum Rx network pharmacy is required • Dispensed by Student Health Center • Out of Network is not covered	Tier 1 $10 Copayment per prescription Tier 2 $30 Copayment per prescription Tier 3 $50 Copayment per prescription
RECREATIONAL ACTIVITIES OR AMATUER SPORTS	100% Preferred Allowance

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	100% of actual costs
MEDICAL REPATRIATION	Actual cost of roundtrip 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 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%

Effective and Termination Dates

1. **Effective dates**
   The Master Policy on file at the school becomes effective at 12:01 a.m., July 1, 2025. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

2. **Termination Dates**
   The Master Policy terminates at 11:59 p.m., June 30, 2026. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

   The Master Policy is a non-renewable 1-year term insurance policy.

3. **Extension of the Benefits**
   The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such conditions both before and after the Termination Date will never exceed the maximum benefit.
After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

4. **Grace Period**
When eligible customer entered the United States up to thirty (30) days before the program start date or stay in the United States up to thirty (30) days after the program end date (but insurance period must be within 365 days).

Pre-Existing Condition Limitations

For Plans that include a Waiting Period for Pre-Existing Conditions, the Waiting Period will be reduced by the total number of months that the Insured Person provides documentation of continuous coverage that provided benefits similar to this Plan provided the coverage was continuous to a date within 63 days prior to the Insured Person's Effective Date.

Preferred Provider and Out-of Network Provider

This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of Preferred Providers. The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as Out-of-Network Providers. However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits.
If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Please contact Our Customer Service area with any questions about In-Network Provider availability at the number on Your ID card.

You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that You verify that Your Physicians are In-Network Providers each time You call for an appointment or at the time of service.

Pre-Authorization

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.

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 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 approve and arrange such emergency medical air transportation and to have coverage. Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment.

*Refer to the ID

Medical Expense Benefits

This section describes Covered Medical Expenses for which benefits are available. **Please refer to the attached Schedule of Benefits for benefit details.**

Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the Definitions section and the Exclusions and Limitations section carefully.

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in Exclusions and Limitations. If a benefit is designated, Covered Medical Expenses include:

Preventive Care

Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent Illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

Adult Wellness Visit and Preventive Services

• Your Physician will measure your height, weight, take your blood pressure and take other routine measurements; review your medical and family history; assess your risk factors for preventable diseases; check vital signs; perform head and neck exam, lung exam, abdominal exam and look for signs of cognitive impairment; test your reflexes; review your health risk assessment questionnaire; update your list of providers and prescriptions; and set up a screening schedule for appropriate preventive services

• Immunizations and vaccinations: Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (flu shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox), COVID-19 (immunizations and vaccinations must be obtained at the Student Health Center or OPTum In-Network pharmacy)

• Preventive screenings (1 per year)

○ Papanicolaou (PAP) screening

○ Mammogram (eligible age: 40 years and over)

○ PSA screening test (eligible age: 50 years and over)

Well childcare visits (children 0-12 months, 9 visits maximum per policy period)

Periodic age specific physical examinations and developmental assessments; office visit; health history; hearing examinations; age related diagnostic tests (up to 12 months only); vaccination and immunization necessary for prevention; and track growth and development in accordance with pediatric guidelines

Emergency Services

1. **Emergency Room**
   Benefits will be paid for the use of a Hospital emergency department or independent freestanding emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after You are moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after You are Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished.
2. **Emergency Ambulance**
   with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to Your home is not covered.

3. **Urgent Care Center**
   for Urgent Care Services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.

4. **Non-Emergency Ambulance Expense**
   Expenses for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (fixed wing) (as appropriate), when the transportation is:

   - From an Out-of-Network Hospital to an In-Network Hospital;
   - To a Hospital that provides a higher level of care that was not available at the original Hospital;
   - To a more cost-effective acute care Hospital/facility; or
   - From an acute care Hospital/facility to a sub-acute setting.

   Transportation from facility to your home is not covered.

Inpatient

1. **Room and Board Expense**.
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

Not Covered Under This Benefits

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.

2. **Intensive Care.**
   See Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Surgery**.
   Physician's fees for Inpatient surgery.

5. **Assistant Surgeon Fees**.
   Assistant Surgeon Fees in connection with Inpatient surgery.

6. **Anesthetist Services.**
   Professional services administered in connection with Inpatient surgery.

7. **Registered Nurse's Services.**
   Registered Nurse's services which are all of the following:
   - Private duty nursing care only.
   - Received when confined as an Inpatient.
   - Ordered by a licensed Physician.
   - A Medical Necessity.

   General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

8. **Skilled Nursing Facility Benefits**
   Services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

9. **Pre-admission Testing**.
   Benefits are limited to routine tests such as:
   - Complete blood count.
   - Urinalysis.
   - Chest X-rays.

10. **Organ Transplant**

    Recipient Surgery for Medically Necessary, non-Experimental and non-Investigative solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and other Covered Medical Expenses when You are the recipient of an Organ Transplant.

Mental Health Disorder and Substance Use Disorder

1. **Inpatient and Outpatient Mental Health Disorder Benefit** for Treatment of Mental Health Disorders as specified on the Schedule of Benefits. Coverage also includes two mental health wellness examinations per Policy Year when performed by a licensed mental health professional.

   We will also pay the expenses incurred for the diagnosis and Treatment of Autism Spectrum Disorder. We will provide coverage for the following Medically Necessary Treatments, provided such Treatments are identified and ordered by a Physician, licensed psychologist or licensed clinical social worker for an Insured Person who is diagnosed with an Autism Spectrum Disorder, in accordance with a Treatment plan developed by a Physician, licensed behavior analyst, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the Insured Person:

   a. Behavioral Therapy;
   b. Prescription drugs, to the extent prescription drugs are a covered benefit for other Covered Sicknesses, prescribed by a Physician, licensed Physician assistant or advanced practice registered nurse for the Treatment of symptoms and comorbidities of Autism Spectrum Disorder;
   c. Direct psychiatric or consultative services provided by a licensed psychiatrist;
   d. Direct psychological or consultative services provided by a licensed psychologist;
   e. Physical therapy provided by a licensed physical therapist;
   f. Speech and language pathology services provided by a licensed speech and language pathologist; and
   g. Occupational therapy provided by a licensed occupational therapist.

   For outpatient Treatment, We may review the Treatment plan, in accordance with Our utilization review requirements, not more than once every six (6) months unless the Insured Person's Physician agrees that a more frequent review is necessary or changes such Treatment plan.

2. **Inpatient and Outpatient Substance Use Disorder Benefit** for Treatment of Substance Use Disorders as specified on the Schedule of Benefits.

   We will also pay the expenses incurred due to Medically Necessary inpatient and outpatient emergency medical care arising from accidental ingestion or consumption of a controlled drug.

Outpatient

1. **Surgery**.

   Physician's fees for Inpatient surgery.

2. **Physical Therapy**

   It must be serviced by licensed therapist.

3. **Dental Treatment.**

   With result of Injury to Sound, Natural Teeth. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

4. **Vision Care Services**
   annual retina exam for an Insured Person diagnosed with an existing condition of the eye, such as glaucoma or diabetic retinopathy.

Office Visits

1. Telehealth or Telemedicine
   for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician or a contracted provider subject to the plan cost share shown on the Schedule of Benefits.
2. Physician's office visit
   Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.
3. Allergy Test and Treatment
   This includes tests that You need such as PRIST, RAST, and scratch tests. Also, includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, allergy serum, and supplies used for allergy therapy.
4. Chiropractic Care
   Treatment of a Covered Injury or Covered Sickness and performed by a Physician.
5. Tuberculosis screening(TB), Titers, QuantiFERON B tests
   when required by the School for high risk Insured Persons.(other than covered under Preventive Care Services)

Diagnostic Lab, Testing and Imagin Service

1. **Lap Test, X-Ray and other Test**
   diagnostic X-ray services when prescribed by a Physician and laboratory procedures when prescribed by a Physician.
2. **Advanced Imaging Services**(CT Scan, MRI and/or PET Scan)
   diagnostic services when prescribed by a Physician.
   Inpatient: services can be allowed in hospital.
   Outpatient: services are allowed not in hospital but in Free-standing facilities
3. **Chemotherapy and Radiation Therapy**
   for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.
4. **Infusion Therapy**
   for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Maternity and Newborn Care

1. **Newborn Care**
   While Hospital Confined and routine nursery care provided immediately after birth.
   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.
2. **Maternity**
   Same as any other Sickness for maternity-related services, including prenatal and postnatal care
   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.

   If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. An earlier discharge may be provided if based on evaluation and availability of a post-discharge Physician office visit or

an in-home nurse visit to verify the condition of the newborn in the first 48 hours after discharge. A shorter length stay must meet the protocols and guidelines for the length of a Hospital Inpatient stay as developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics

Not Covered under this Benefit
Eltetive C-Sections are not covered.

3. **Complication of Pregnancy**
   Arise within the ten (10) month Waiting Period are not covered.
   Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider.
   This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Plan Administrator will determine coverage upon receipt of the Pre-Authorization request.

   Not Covered under this Benefit:
   Maternity benefits for an insured Dependent child are not covered. Fertility/infertility services, including but not limited to tests, treatments, medications, and/or procedures, complications of that pregnancy, delivery, postpartum care, and care or treatment for an individual acting as a surrogate including delivery of the child are not covered under this benefit.

4. **Elective Abortion**
   Benefits are provided for the voluntary termination of pregnancy if performed at a licensed facility and meets the guidelines of the state where performed.

Prescription Drugs

medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-authorization. These prescription requirements help Your prescriber and pharmacists check that Your outpatient Prescription Drug is clinically appropriate using evidence-based criteria.
Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.
Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth. You're covered for all types of medicine — some more expensive, and some less

- Tier1(Generic): the lowest cost
- Tier2(Brand): a slightly higher cost
- Tier3(Non-preferred brand): a higher cost than Brand
- Tier4(Preferred Specialty): a highest cost

1. **Off-Label Drug Treatment**
   When Prescription Drugs are provided as a benefit under this Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

   -The drug is approved by the FDA;
   -The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
   -The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical practice guideline).

When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

As it pertains to this benefit, life threatening means either or both of the following:

- Disease of conditions where the likelihood of death is high unless the course of the disease is interuuupted; or
- Disease of conditions with a potentially fatal outcome and where ethe end point of clinical intervention is survival

2. **Dispense as Witten**

If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: “Dispense as Written” (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and You request a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, You will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs. This DAW penalty does not apply to Your Out-of-Pocket Maximum or Deductible.

3. **Spense limit**

30 day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for 1 cost sharing amount for up to a 30 day supply. However, if the Prescription Drug dispensed is the smallest package size available and exceeds a 30 day supply, You are responsible for the cost sharing defined for the day supply as shown in the Schedule of Benefits. in case of over 30 days up to 90 days, additional copay will be charged.

4. **Tier changes**

The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.fivepointsbenefitplans.com or by calling the number on Your ID card.

5. **Compounded Prescription Drugs**

when they contain at least 1 ingredient that is a covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

6. **Contraceptives**

Your Outpatient Prescription Drug benefits cover certain Prescription drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a Physician, physician assistant, or advanced practice registered nurse and the prescription is submitted to the pharmacist for processing. Your outpatient Prescription Drug benefits also cover related services and supplies needed to administer covered devices. At least 1 form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive prescription drugs by referring to the Formulary posted on Our website at www.fivepointsbenefitplans.com or calling the toll-free number on Your ID card.

7. Diabetic supplies

The following diabetic supplies may be obtained under Your Prescription Drug benefit upon prescription by a Physician:

Insulin

- Insulin syringes and needles
- Blood glucose and urine test strips
- Lancets
- Alcohol swabs
- Blood glucose monitors and continuous glucose meters
- Diabetic ketoacidosis devices subject to the limits shown on the Schedule of Benefits

You can identify covered diabetic supplies by referring to the Formulary posted on Our website at www.fivepointsbenefitplans.com or by calling the toll-free number on Your ID card. Refer to the Diabetic Services and Supplies (including equipment and training) provision for diabetic services and supplies covered under the Diabetic Services and Supplies (including equipment and training) benefit.

8. **Preventive Care drugs and Supplements**

   Covered Medical Expenses include preventive care drugs and supplements (including over the counter drug and supplements as required by the Affordable Care Act (ACA) guidelines when prescribed by a Physician and the prescription is submitted to the pharmacist for processing.

Other Services

1. **Alternative Medicine**

   Acupuncture, Homeopathy or Chinese Medicine is covered. Treatment is covered by certified and homeopathy Specialist

2. **Home Health Care**

   Services received from a licensed home health agency that are:

   - Ordered by a Physician.
   - Provided or supervised by a Registered Nurse in the Insured Person's home.
   - Pursuant to a home health plan.

   Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

   Benefits also include Private Duty Nursing services provided by a Registered Nurse or licensed practical nurse only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services include teach and monitoring of complex care skills such as a tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care.

   For the purposes of this benefit "Private Duty Nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or licensed practical nurse (L.P.N). Private duty nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private duty nursing does not include Custodial Care Service.

   The limit of visit of Home Health Care is 12 visits per Policy year

3. **Prosthetic and Orthotic Devices**

   To replace all or part of a body organ or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part when Medically Necessary and prescribed by a Physician.

   We will also pay the expenses incurred for the cost of a hair prosthesis made necessary for an Insured Person whose hair loss results from chemotherapy or radiation Treatment when prescribed by a licensed oncologist.

4. **Hospice**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

5. **HIV/AIDS**
Benefits are provided for Medically Necessary, non-Experimental services, supplies and medications for the treatment of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), sexually transmitted diseases and all related conditions that are not Pre-Existing Conditions

6. **Diabetic Services and Supplies**
Includes coverage for the cost associated with equipment, supplies, and self-management training and education for the Treatment of all types of diabetes mellitus when prescribed by a Physician.
Benefits include, but are not limited to, the following services and supplies:
   - Insulin preparations
   - Foot care to minimize the risk of infection
   - Injection aids for the blind
   - Diabetic test agent
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagon
   - Glucagon emergency kits

Equipment
   - Foot care to minimize the risk of infection
   - Injection aids for the blind
   - Diabetic test agent
   - Prescribed oral medications whose primary purpose is to control blood sugar
   - Injectable glucagon
   - Glucagon emergency kits
   - Insulin preparations

Training
   - Self-management training including:
      - 10 hours of initial training
      - 4 hours extra training due to changes in Your condition
      - 4 hours of training due to new developments in the treatment of diabetes.
   - Patient management materials that provide essential diabetes self-management information

"Self-management training" is a day care program of educational services and self-care designed to instruct You in the self-management of diabetes (including medical nutritional therapy). The training must be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or Physician whose scope of practice includes diabetic education or management.

This coverage includes the Treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the Treatment of elevated blood glucose levels during pregnancy.

Refer to the Prescription Drug provision for diabetic supplies covered under the Prescription Drug benefit.

7. **Durable Medical Equipment**

Benefits are provided for items which are designed for and able to withstand repeated use by more than one person and customarily serve a medical purpose. Such equipment includes but is not limited to, wheelchairs, Hospital beds, respirators, and dialysis machines. Such Durable Medical Equipment (DME) must be:

- Prescribed by a Physician,
- Customarily and generally useful to a person only during a covered Illness or Injury,
- Equipment must be appropriate for use in the home and are not disposable, and
- Determined by the Insurer to be Medically Necessary and appropriate.

Allowable rental fee of the Durable Medical Equipment must not exceed the purchase price. Charges for repairs or replacement of artificial devices or other Durable Medical Equipment originally obtained under this Plan will be paid at 50% of the allowable reasonable and customary amount

Not Covered Under this Benefit

Some items not covered under Durable Medical Equipment include but are not limited to the following:

- Comfort items such as telephone arms and over bed tables, or
- Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers, or
- Miscellaneous items such as exercise equipment, heat lamps, heating pads, toilet seats, bathtub seats, or
- The customizing of any vehicle, bathroom facility, or residential facility.

High performance devices for sports or improvement of athletic performance, and power enhancement or power- controlled devices, nerve stimulators, and other such enhancements are not covered. Prosthetic limbs and other devices intended to replace the functionality of the body part being replaced and the repair and replacement of such devices are not covered.

8. **Alcohol and Substance Abuse Rehabilitative Treatment**

Benefits are provided for Inpatient and Outpatient services including diagnosis, detoxification, counseling, and other medical treatment rendered in a Physician's office or by an Outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that the Insured Person needs to continue such treatment.

9. **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. Examples of such covered activities include, but are not limited to: kayaking, snorkeling, paddle boarding, sailing, snow skiing (groomed trails only), white water rafting levels 1-3, and scuba diving to a depth less than 15 meters. In addition, snowboarding (groomed trails only) and using an ATV are limited to a maximum benefit of $50,000 per Period of Insurance.

Not Covered Under this Benefit

1. Hazardous or Extreme Sports or activities, professional sports or activities, Intercollegiate, Interscholastic, Intramural and Club sports.

2. Accidents caused as a result of the Insured Person's Pre-Existing Condition *(Dependents only)*.
3. Participation in official competitions and their qualifying rounds, as well as attempts to break records.
4. 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.

Medical evacuation and Repatriation

1. **Medical evacuation**

(International Students and Domestic Students and their Dependents) 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.

2. **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

General Exclusions

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)).**

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. **Alcohol and Substance Abuse:** Medical expenses related to diagnosis, detoxification, counseling or other rehabilitative services unless the benefit is provided for on the Schedule of Benefits.
2. **Breast Reductio**n: All services and treatments.
3. **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.
4. **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.
5. **Dental Care:** a) Except for Accidental injury to sound, natural teeth b) unless pediatric dental is shown on the Schedule of Benefits.
6. **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.
7. **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.
8. **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.
9. **Genetic Screening:** Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
10. **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.
11. **Home Country:** a) All medical charges incurred in the Insured Person's Home Country, in excess of the amount shown
    on the Schedule of Benefits.
12. **Illegal Activities:** Injuries or Illnesses resulting or arising from or occurring during the commission of an assault or felony.

13. **Immunizations for Travel:** Vaccines and preventive medications recommended or required for travel to specific countries.

14. **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.
15. **Nasal Surgery:** Deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus surgery except for treatment of a covered Injury.
16. **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.
17. **Organ Transplant:** Organ transplant and related procedures and expenses.
18. **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.
19. **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.
20. **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.
21. **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*.
22. **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.
23. **Sexually Transmitted Diseases** services, supplies and medications for sexually transmitted diseases and all related conditions.
24. **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).
25. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
26. **Smoking Cessation:** Treatments and other expenses, whether or not recommended by a Physician.
27. **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

28. **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.

29. **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.

30. **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.
31. 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.
32. 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.
33. **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

NON-MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

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.

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.

Filing a claim on Injury or sickness benefits

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.. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer.

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.

2. **Claim submission**

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

3. **Reimbursement**

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.

4. **Settlement of Claims**

When claims are presented to the Insurer, the Allowed Amount will be applied towards the Deductible. Once the Deductible has been satisfied, all Allowable Amount will be paid at the percentage listed on the Schedule of Benefits, up to the listed benefit maximum. Note the Allowed Amount is 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 Allowed Amount 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.

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.

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.

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.

General Provisions

GRACE PERIOD: A grace period of 10 days for monthly premium Policies and 31 days for all other Policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, 6006 N. Mesa st, Suite 108 Coronado Tower El Paso, TX 79912 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORM : You can find out Claim Form at broker's site or we will furnish to the claimant such forms as are usually furnished by Us for filing proofs of Loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of Loss requirements by giving Us a written statement of the nature and extent of the Loss within the time limits stated in the Proofs of Loss provision.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid upon receipt of due written proof of such loss. All claims and indemnities payable under the terms of this Policy of accident and health insurance shall be paid within 30 days following receipt by the Company of due proof of loss. Failure to pay within such period shall entitle the Insured to interest at the rate of nine percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

PAYMENT OF CLAIMS: Benefits will be paid to You. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to Your estate. Any other accrued indemnities unpaid at the time of Your death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $2,000.00, to any one relative by blood or connection by marriage to You who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless You direct otherwise, in writing, by the time proofs of Loss are filed or when an ambulance provider is entitled to be paid directly

pursuant to applicable law. We cannot require that the services be rendered by a particular provider.

Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity:
1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and,
2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to:
(1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and
(2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proofs of loss are required to be furnished.

Assignment
You may assign Out-of-Network benefits payable under this Certificate. In-network benefits are billed directly by the provider. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed with Us. We assume no responsibility regarding the validity of any assignment or payment made without notice of a prior assignment.

SUBROGATION: Whenever this Policy has paid benefits because of Sickness or an Injury to any Insured Person resulting from a third party's wrongful act or negligence, to the extent of such payment the Company shall reserve the right to assume the legal claim any Insured Person may have against that third party. This means that the Company may choose to take legal action against the negligent third party or their representatives and to recover from them the amount of claim benefits paid to the Insured Person for loss caused by the third party.

RIGHT OF REIMBURSEMENT: If an Insured Person incurs expenses for Sickness or an Injury that occurred due to the negligence of a third party:

The Company has the right to reimbursement for all benefits paid by the Company from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person’s parents, if the Insured Person is a minor, or Insured Person’s legal representative as a result of that Sickness or Injury.

The Company is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Company for that Sickness or Injury.

The Company has the right to reimbursement out of all funds the Insured Person, the Insured Person’s parents, if the Insured Person is a minor, or the Insured Person’s legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are

obligated in respect of any covered Injury or Sickness as their liability may appear.
The Company will not seek reimbursement for overpayment of a claim made to a provider after 12 months from the date of the first payment on the claim.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies. The Insured Person designating a beneficiary retains the right to change that designation unless he/she make the designation irrevocable.

Appeal and Grievance Program

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.