International
Student
Health
Insurance

DIANins



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SPECTRUM
LIFE

INTERNATIONAL STUDENT PLAN SUMMARY

This plan summary contains a description of the insurance benefits provided by the insurance plan you have purchased.

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

This insurance is not subject to and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). This insurance shall be governed by the laws of the St. Kitts and Nevis and is subject to the exclusive Jurisdiction of the courts of St. Kitts and Nevis.

NOTE THE POLICY CONTAINS THE DEFINITIONS AND DETAILS OF THE BENEFITS OFFERED BY THE INSURER. THE SCHEDULE OF BENEFITS REFLECTS THE BENEFITS AND LIMITS THE INSURED PERSON HAS SELECTED.

PLEASE REFER TO THE SCHEUDLE OF BENEFITS FOR THE SPECIFIC BENEFITS AND LIMITS APPLICABLE TO YOUR COVERAGE.

IN THE EVENT OF ANY CONFLICT BETWEEN THE POLICY AND THE SCHEDULE OF BENEFITS, THE SCHEDULE OF BENEFITS WILL GOVERN.

TABLE OF CONTENTS

1. GENERAL PROVISIONS	4
2. SCHEDULE OF BENEFITS	4
3. ELIGIBLITY	12
4. PREMIUM, CANCELLATION, AND POLICY PROVISIONS	15
5. PRE-AUTHORIZATION	16
6. MEDICAL COVERAGE	17
7. PREVENTIVE CARE	18
8. EMERGENCY SERVICES	18
9. HOSPITALIZATION AND INPATIENT BENEFITS	20
10. MENTAL HEALTH AND SUBSTANCE DISORDER	21
11. OUTPATIENT SERVICES	22
12. SURGICAL BENEFITS (INPATIENT/OUTPATIENT)	23
13. MATERNITY CARE	23
14. PRESCRIPTION DRUGS	24
15. OTHER BENEFITS	26
16. CLAIMS PROCEDURES	29
17. SUBROGATION, REIMBURSEMENT AND ASSISGNMENT	30
18. COMPLAINTS PROCEDURE	31
19. NOTICE OF PRIVACY PRACTICES	31
20. EXCLUSIONS	32
21. DEFINITIONS	36

1. GENERAL PROVISIONS

1.1 Parties to the Policy

This international student policy is issued by **Spectrum Life Ltd.** domiciled in St. Kitts and Nevis. Spectrum Life Ltd. hereinafter shall be referred to, sometimes collectively, as the **Company, Insurer, We, Us, or Ours.**

The international student, who is not a permanent resident or citizen of the United States, hereinafter shall be referred to as the **Insured Person, Insured Student or Policyholder.**

Any references in this Policy to the international student or Insured Student that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

1.2 Program Governance

This policy is delivered through a coordinated structure involving Spectrum Life Ltd., Redbridge Group LLC ("Redbridge") and DIANins each performing a distinct role to ensure financial security, compliance oversight, and best-in-class claims administration.

- **Spectrum Life Ltd.** — Insurance Company
  This Policy is issued by Spectrum Life Ltd. located in St. Kitts and Nevis.
- **Redbridge Group LLC ("Redbridge")** — Plan Administrator
  The Plan Administrator performs administrative, operational, medical management, and coordination services solely on behalf of the Insurer and does not insure, underwrite, or assume insurance risk under this Policy.
- **DIANins** — Plan Marketer
  The Plan Marketer who assists international students with enrollment and claims.

1.3 Entire Policy and Changes

This Policy, the Schedule of Benefits and the international student application comprise the entire contract between the parties. No change may be made to this Policy unless it is approved by an executive officer of the Insurer. This approval must be endorsed on or attached to the Policy. No agent or other person may change this Policy or waive any of its provisions.

Should any term and/or coverage under the Plan change, the Plan Administrator shall not be responsible for services rendered prior to receipt of written notice of such change.

2. SCHEDULE OF 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	Aetna
AREA OF COVERAGE	Worldwide excluding Home Country
MAXIMUM BENEFIT PER COVERED ILLNESS OR INJURY PER INSURED PERSON	Unlimited
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	 $500 per Insured Person $750 per Insured Person
COPAYMENTS	
Copayments do not apply to the Deductible or the Out-of- Pocket-Maximum	
Student Health Center Copayment	$0 per visit
Physician/Specialist Office Visit Copayment	$25 per visit
Hospital Copayment per Admission	$0 per visit
Urgent Care Center Copayment	$50 per visit
Emergency Room Copayment (waived if admitted)	$150 per visit
OUT-OF-POCKET-MAXIMUM PER PERIOD OF INSURANCE PER INSURED PERSON •In-Network or Out-of-Network The Deductible, Copayments (including Prescription Medication) does not apply to the Out-of-Pocket Maximum.	 •In-Network: $7,000 •Out-of-Network: $14,000
PRE-EXISTING CONDITION LIMITATION	Student: Pre-Existing Conditions are covered without a Waiting Period Dependents: Pre-existing Conditions are covered after a 24 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 70% of UCR when Out-of-Network Providers in the U.S. are used. Coinsurance outside the USA, excluding M1/M2 visa holders is 80% of UCR.

HOSPITALIZATION AND INPATIENT BENEFITS	
ACCOMODATIONS INCLUDING SEMI-PRIVATE ROOM	80% Preferred Allowance
INTENSIVE CARE/CARDIAC CARE	80% Preferred Allowance
INPATIENT CONSULTATION/VISIT BY A PHYSICIAN, OSTEOPATH OR SPECIALIST	80% Preferred Allowance
DIAGNOSTIC TESTING AND HOSPITAL MISCELLANEOUS EXPENSE AND X-RAY AND LABORATORY	80% Preferred Allowance
PRE-ADMISSION TESTING Within 3-5 working days prior to admission	80% Preferred Allowance
INPATIENT REHABILITATION •Maximum Benefit per Period of Insurance: 45 days •Must be confined to facility immediately following a hospital stay	80% Preferred Allowance
OUTPATIENT BENEFITS	
PRIMARY CARE VISIT •Office visit Copayment applies •Maximum Benefit: 1 visit per day per specialty	80% Preferred Allowance
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	80% 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	80% Preferred Allowance
THERAPEUTIC SERVICES •Maximum Benefit per covered Illness or Injury: 12 visits, 1 visit per day •Office visit Copayment applies	80% 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	80% 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.	80% Preferred Allowance
EMERGENCY BENEFITS	
EMERGENCY ROOM AND MEDICAL SERVICES •Copayment waived, if admitted •Non-emergency use of the emergency room is reduced to 30% Coinsurance In Network and 20% Out of Network	80% Preferred Allowance
AMBULANCE SERVICES •Emergency local ground ambulance	80% 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	80% Preferred Allowance
PALLIATIVE DENTAL CARE •Sudden onset of pain •Maximum Benefit per Period of Insurance: $600	80% 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 Insurer, acting through the Plan Administrator in an administrative capacity, will determine eligibility and coverage in accordance with the terms of the Policy.	80% Preferred Allowance
ELECTIVE ABORTION •Maximum Benefit per Period of Insurance: $1,500	80% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
MENTAL HEALTH Outpatient - Office visit Copayment applies	80% Preferred Allowance
PREVENTIVE 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
TITERS •Titers benefit related to immunization for the Polio virus immune status, Hepatitis B surf AB, Hep B, Hep A, Varicella-Zoster AB, IgG, MMR, Tdap, and Rubella.	100% Preferred Allowance
TUBERCULOSIS SCREENING AND TESTING •TB screening and testing, if testing is not covered under the Preventive Care Services •If it is covered by Student Health Fee, payment will be denied. •It is only allowed at Student Health Center	100% Preferred Allowance
ALTERNATIVE MEDICINE (CHIROPRACTIC, HOMEOPATHIC CARE AND ACUPUNCTURE) •Maximum Benefit per Period of Insurance: $500 •Office visit Copayment applies	80% Preferred Allowance

CANCER CARE AND ONCOLOGY	80% 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	80% Preferred Allowance
HOSPICE CARE •Inpatient Maximum Benefit per Period of Insurance: 45 Days •Outpatient Maximum Benefit per Period of Insurance: $5,000	80% Preferred Allowance
AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions	80% Preferred Allowance
DURABLE MEDICAL EQUIPMENT •Reimbursement of rental up to the purchase price	80% UCR
ALCOHOL AND SUBSTANCE ABUSE •Rehabilitative treatment only	80% Preferred Allowance
PRESCRIPTION MEDICATIONS •Up to 31-day supply per prescription •Includes oral contraceptives •Global Reach 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	80% Preferred Allowance

PEDIATRIC VISION BENEFITS
The following Benefits are provided for covered vision services for Dependent Child.

VISION CARE SERVICE	FREQUENCY OF SERVICE	BENEFIT
ROUTINE VISION EXAMINATION Or refraction only in lieu of a complete exam	ONCE PER YEAR	50% UCR
EYEGLASS LENSES AND FRAMES •Single Vision •Bifocal •Trifocal •Lenticular	ONCE PER YEAR MAXIMUM BENEFIT OF $150	50% UCR
CONTACT LENSES •Covered Contact Lens Selection •Necessary Contact Lenses	LIMITED TO A 12-MONTH SUPPLY	50% UCR

PEDIATRIC DENTAL BENEFITS
The following Benefits are provided for covered dental services for Dependent Child.

DIAGNOSTIC SERVICES •Intraoral Bitewing Radiographs (Bitewing X-ray – two films). Limited to 1 series of films per 6-months •Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12-months. Covered as a separate benefit only if no other services were performed during the visit other than X-rays.	50% UCR
PREVENTATIVE SERVICES •Dental Prophylaxis (cleanings) Limited to 2 times per 12-months •Fluoride Treatments Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50% UCR

NON-MEDICAL EXPENSE BENEFITS

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

MEDICAL EVACUATION	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%

3. ELIGIBILITY

3.1 Eligible Classes

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 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. A student who graduates or withdraws after 31 days of the period for which he or she is enrolled will remain covered under this policy for the term purchased and no refund will be allowed.

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

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 only.

Who is Eligible:

- Class 1: International students (F1, J1, M1 visa) officially enrolled in an accredited higher education institute in a full- time associate, bachelor's, master's or doctoral program between the age of 17-45. However, this does not apply to students who are in their final term or enrolled part-time as a prospective graduate * 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

Who is not Eligible:

- Students taking distance learning, home study or OPT students

3.2 Persons Eligible to be an Insured Person

The Insured Person on this Plan is a Non-United States Citizen travelling outside their Home Country and travelling to the United States. Their true, fixed and permanent home and principal establishment is outside of the United States, and they hold a current and valid passport, and for whom proper Premium payment has been made when due.

Insured Persons are those persons described as an Eligible Class. Students who are United States citizens are not eligible for coverage.

3.3 Eligible Dependents
Coverage can be extended to the following members who are traveling with the student who is the Insured Person. Insured Dependents may include:

- The spouse or domestic partner up to age 64.
- Dependent children up to age 19, if unmarried. Dependent children include the Insured Person's natural children, legally adopted children, and stepchildren that reside with the insured.

Dependents who are United States citizens or permanent legal residents of the United States are not eligible for coverage.

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

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

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

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

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

3.5 Addition of a Newborn Baby or Legally Adopted Child
Born Under a Pregnancy Covered by the Maternity Benefit or Adopted as of the Date of Birth:

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

- Written notification is made to the Insurer within 31 days of the date of birth, or in the case of an adopted child, a copy of the legal adoption papers is required. The newborn child shall be accepted from the date of birth.
- The newborn baby will be enrolled for the same coverage as the Insured Person.
- Conception was after the 10-month waiting period.

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

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

- The Insured Person will provide written notification to the Insurer (Official Copy of Birth Certificate), and
- A Health Statement must be submitted detailing the medical history of the child,

- Coverage will become effective as of the date of notification, provided the Insurer has approved the Health Statement, Coverage is not guaranteed and is based upon the health of the newborn baby,
- Any applicable Pre-existing condition limitation will apply.

3.6 Adoption of a Legally Adopted Child After the Date of Birth
A child adopted after the date of birth may be covered providing the following applies:
- The child must be younger than 19 years old, and
- The Insured Person will provide written notification to the Insurer (an official copy of the legal adoption papers is required with the notification), and
- A Health Statement must be submitted detailing the medical history of the child.

Coverage will be contingent based upon the terms and conditions of the Policy. Additionally,
- Coverage will become effective as of the date of notification, and
- Any applicable Pre-Existing Condition limitation will apply.

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

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

Newly Enrolled and Arriving Students
To be eligible for the Extended Coverage Benefit and before any benefits will be paid:
1. A newly enrolled and arriving student must have enrolled in full-time studies at the higher education institution, and
2. All Premiums must be paid.

Coverage under the Extended Coverage Benefit will become effective on the later of:
1. 30 days prior to the beginning of the term, or, if later,
2. On the first day the qualifying, newly enrolled and arriving student arrives in the United States.

Students Concluding their Studies
An Insured Person may extend coverage for a maximum of 60 days while remaining in the United States following graduation or completion of an educational program. To be eligible for the Extended Coverage benefit and before any benefits will be paid:
1. The Insurer must receive the request for Extended Coverage prior to the termination of the Insured Person's coverage, and
2. All Premiums must be paid.

Coverage under the Extended Coverage Benefit will terminate on the earlier of:
1. 60 days following the Insured Person's graduation or completion of an educational program, or
2. The date of departure from the United States.

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

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

4. PREMIUM, CANCELLATION AND POLICY PROVISIONS

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

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.

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

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

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

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

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

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

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

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

4.8 Denial of Liability
Neither the Insurer, Plan Administrator nor Plan Marketer shall be liable for the quality of medical care rendered by any provider, nor for delays, acts, omissions, negligence, or services provided by third-party medical providers, transportation vendors, or healthcare facilities. This insurance coverage does not give the Insured Person any claim, right or cause of action against the Insurer, Plan Administrator or Plan Marketer based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

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

4.10 Pre-Existing Condition Limitation
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.

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

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

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

5. PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

Pre-Authorization is a process by which an Insured Person obtains approval for certain medical procedures or treatments prior to the commencement of the proposed medical treatment. During this process, the Insured may also be directed to in-Network Providers capable of providing the appropriate level of care. The Redbridge Pre-Authorization department must be contacted a minimum of 10 business days prior to a non-urgent scheduled procedure or treatment date, or within 48 hours (or as soon as reasonably possible) after an emergency admission. To initiate the Pre- Authorization process, please contact the Redbridge Pre-Authorization department at service@redbridge.cc. or Telephone: 305-709-0561 or toll free: 1-800-791-4531.

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

The following services require Pre-Authorization:

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

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

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

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

The Plan Administrator coordinates medical evacuation services on behalf of the Insurer and neither the Plan Administrator, Insurer or Plan Marketer shall be liable for delays, governmental restrictions, weather conditions, transportation interruptions, or acts or omissions of third-party transportation providers.

6.MEDICAL COVERAGE

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

EXCESS PROVISION

No benefit under this Plan is payable for any Covered Expense incurred for Injury or Illness which is paid or payable by Other Valid and Collectible Medical Insurance except under an automobile insurance policy.

Covered Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with Plan provisions or requirements.

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

- Incurred as a result of illness or accidental injury under the care of a Physician
- Ordered or recommended by a licensed Health Care Provider and under the scope of the Physician's licensing.

- Medically necessary, and
- Delivered in an appropriate medical setting.

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:

7. 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 Global Reach 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.

8. EMERGENCY SERVICES

8.1 Serious Accident Hospitalization
An unforeseen trauma occurring without the Insured's intention, which implies a sudden external cause and violent impact on the body, resulting in demonstrable bodily injury that requires immediate Inpatient hospitalization for 24 hours or more within the next few hours after the occurrence of the severe injury to avoid loss of life or physical integrity. Severe injury shall be determined to exist upon agreement by both the treating Physician and the Insurer's medical consultant, after review of the triage notes, emergency room and Hospital admission medical records. The deductible will be waived for the whole episode if the Insured is admitted to a hospital for at least 24 hours immediately following the Accident. Any subsequent admissions or services occurred after the discharge will apply deductible.

8.2 Ground Ambulance Services
Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care. The use of ambulance services for the convenience of the Insured will not be considered a covered service.

8.3 Air Ambulance and Medical Evacuation
Utilization of the air ambulance and medical evacuation requires the prior approval of Redbridge. In the event of an Emergency that may require medical evacuation, contact the Redbridge Pre-Authorization department at the 24/7 emergency response center worldwide collect at 305-709-0561, toll free in USA at 1-800-709-0561, or via email at service@redbridge.cc in advance to approve and arrange such medical air transportation. Redbridge's contact information can also be located on the Insured's medical ID card.

- Emergency evacuation is only covered if related to a covered condition under the Policy, for which treatment cannot be provided locally, and transportation by any other method is not medically advisable.
- Redbridge retains the right to decide the facility to which the Insured shall be transported. Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment or the student's Home Country. If the Insured Person chooses not to be treated at the facility and location arranged by the Insurer, then transportation expenses shall be the responsibility of the Insured. Failure to arrange transportation as indicated will result in non-payment of transportation costs.
- 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.
- The Insured agrees to hold the Insurer, including all of its subsidiaries, affiliates and parents, harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or governmental restrictions; errors, omissions, or negligence by the pilot, driver, or crew; or operational, weather, or any other adverse conditions.

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

8.5 Emergency Dental Care
Benefits are provided for Emergency Dental treatment and restoration of sound natural teeth as a result of an Accident. All treatment must begin within 72 hours of the Accident and be completed within 120 days of such accident. Routine dental treatment is not covered unless shown as included in the Schedule of Benefits. Damage due to chewing or biting is not covered.

8.6 Treatment in Urgent Care Centers
This Policy covers treatments in Urgent Care Centers in the United States of America as outlined in the Schedule of Benefits.

8.7 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

9. HOSPITALIZATION AND INPATIENT BENEFITS

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

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

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

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.

9.2 Medical Treatments, Medicines, Laboratory, Diagnostic Tests, and Hospital Miscellaneous Expense
Benefits are provided for Medically Necessary diagnosis and treatment of the Illness or Injury for which an Insured Person is hospitalized, the following services are also covered:
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services,
- Laboratory testing,
- Durable medical equipment,
- Diagnostic X-ray examinations,
- Radiation therapy,
- Respiratory therapy, and
- Chemotherapy.

9.3 Inpatient Consultation/Visit by a Physician or Specialist
Benefits are provided for the reimbursement of one Physician visit per day while the Insured Person is a patient in a Hospital or Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the surgical fee and Insurer will not pay separate charges for such care.

If Medically Necessary, the Insurer may elect to pay more than one visit of different Physicians on the same day if the Physicians are of different specialties. The Insurer will require submission of records and other documentation of the Medical Necessity for the intensive services.

9.4 Pre-Admission Testing
Benefits are provided for any service related to an Insured Person's planned Inpatient Admission or same day surgery that is performed on the day of, or within the period specified in the Schedule of Benefits prior to the day of, an Insured Person's planned Inpatient Admission or same day surgery service.
Pre-Admission Testing services are considered related to an Inpatient Admission or same day surgery if the Outpatient principal diagnosis is similar to, or the same as, the Inpatient or same day surgery diagnosis.

9.5 Extended Care Facility Services and Inpatient Confinement
Benefits are provided for Inpatient confinement and services provided in an approved Extended Care Facility following, or in-lieu-of, an admission to a Hospital because of a covered Illness, disability, or Injury. Care provided must be at a skilled level and is payable in accordance with the current Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered. Coverage for confinement is subject to the Insurer approval. Covered services include the following:

- Skilled nursing and related services on an Inpatient basis for patients who require medical or nursing care for a covered Illness. A confinement includes all approved Extended Care Facility admissions not separated by at least 180 days.
- Rehabilitation for patients who require such care because of a covered Illness, disability, or Injury.

10. MENTAL HEALTH AND SUBSTANCE DISORDER

10.1 Mental Health Benefits
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.

10.2 Substance Abuse Benefits
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.

Inpatient and/or Outpatient treatment for psychological or physical dependence on alcohol or other mind-altering drugs. A Physician, licensed clinical psychologist, social worker, or licensed professional counselor must provide all rehabilitation services to the Covered Person when he/she is either an Inpatient in a general medical Hospital, a psychiatric Hospital, or a residential treatment facility, or as an Outpatient in an approved Outpatient setting, or a Provider's office.

11. OUTPATIENT BENEFITS

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

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

Benefits are also provided for Medically Necessary advanced imaging recommended by a Physician or a Specialist to diagnose or treat an Illness or Injury.
- Magnetic Resonance Imaging (MRI),
- Computed tomography (CT),
- Positron Emission Tomography (PET), and
- Other biological imaging procedures.

11.3 Physical Therapy
Insurer will provide benefits for Medically Necessary physical therapy treatment rendered to an Insured as an Outpatient of a Hospital, Provider's office, or approved independent facility. Benefits for facility and professional services for such services are payable, if shown on the Schedule of Benefits. Benefits are provided for a covered Illness and must be pursuant to a physician's written treatment plan, which contains short- and long-term treatment goals and is provided to Insurer for review. Services must produce significant improvement in the Insured's condition in a reasonable and predictable period of time; and
- Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed; or
- Be necessary to the establishment of an effective maintenance program.

11.4 Chiropractic Care
Benefits are provided for the services listed on the Schedule of Benefits.
Benefits are provided for a covered Illness or injury and performed by a Physician and must be pursuant to a physician's written treatment plan, which contains short- and long-term treatment goals and is provided to Insurer for review. Services must produce significant improvement in the Insured's condition in a reasonable and predictable period of time; and
- Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed; or
- Be necessary to the establishment of an effective maintenance program.

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

11.6 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.

11.7 Allergy Test
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.

11.8 Tuberculosis screening (TB), Titers, QuantiFERON B tests
If required by the school for high risk Insured Persons (other than covered under Preventive Care Services).

12. SURGICAL BENEFITS (INPATIENT/OUTPATIENT)

12.1 Surgical Services
Benefits are provided for covered surgical services received in a Hospital, outpatient facility, daycare treatment facility, Physician's office or other approved facility. Surgical services include use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, obstetrical delivery, and other Medically Necessary services. When Medically Necessary, assistant surgical fees will be paid

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

13. MATERNITY CARE

The following maternity benefits are covered and are applicable to any condition related to pregnancy, including but not limited to childbirth, prenatal, miscarriage and premature birth. The following benefits are only available to the insured Employee or insured spouse. Maternity benefits for an insured Dependent daughter are not covered.
Before the end of your first trimester, contact the Redbridge Pre-Authorization department to declare your pregnancy and expected delivery date for assistance in finding the best medical facility and resources.
Upon entering your third trimester, request pre-authorization.
Conception must occur at least 10 (ten) months after the effective date.

13.1 Physician and Obstetrician Services
Benefits are provided for the following maternity related benefits up to the limit described on the Schedule of benefits:

- Obstetrical and other services rendered in a licensed Hospital or approved birthing center, including anesthesia, delivery, Medically Necessary Caesarean section, prenatal and postnatal care for any condition related to pregnancy, including but not limited to childbirth and miscarriage. Elective Caesarean sections are not covered, and
- All prenatal and postnatal Physician's office visits, laboratory and diagnostic testing, and
- Prenatal vitamins are covered during the term of the pregnancy only, if prescribed by a Physician.
- Delivery is the only benefit that will be available to mothers who have had fertility/infertility treatments, drugs, or procedures. The delivery only benefit is not considered a Covered Pregnancy.
- Elective C-sections are not covered

Benefits in a Hospital length of stay in connection with childbirth for the mother or newborn child, in no event, will be less than: (i) 48 hours after a non-Cesarean delivery; or (ii) 96 hours after a Cesarean Section. This does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). Your Provider is required to obtain authorization for prescribing an Inpatient Hospital stay that exceeds 48 hours (or 96 hours).

13.2 Complications of Pregnancy
Maternity complications and/or newborn complications of birth (not related to Congenital or hereditary disorders), such as miscarriage, prematurity, low birth weight, jaundice, hypoglycemia, respiratory distress, and birth trauma are covered as follows:

- This benefit shall only apply if all the stipulations under maternity related services have been met.
- This benefit does not apply to complications related to any condition excluded or not covered by this Policy, including, but not limited to maternity and newborn complications of birth in a pregnancy that is the result of any type of fertility treatment or any type of assisted fertility procedure, or non-covered pregnancies.
- There is a 10-month waiting period for coverage.

13.3 Newborn Infant Care Services
Benefits are provided for Hospital nursery services and medical care provided by the attending Physician for newborn infants in the Hospital are covered. Such services include but are not limited to general exams, immunizations, hearing tests, blood test for Phenylketonuria (PKU), and circumcision. Charges for Hospital nursery services and professional
services for the newborn infant are covered separately from the mother's Maternity benefits and are subject to satisfaction of the Individual Deductible and Coinsurance. Refer to Addition of a Newborn Baby.

13.4 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.

14. 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.

- Tier 1 (Generic): the lowest cost
- Tier 2 (Brand): a slightly higher cost
- Tier 3 (Non-preferred brand): a higher cost than Brand

14.1 Off-Label Drug Treatment
When Prescription Drugs are provided as a benefit under this Policy, 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), if all 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 interrupted; or
- Disease of conditions with a potentially fatal outcome and where ethe end point of clinical intervention is survival

14.2 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.

14.3 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.

14.4 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 by emailing Redbridge customer service at amgroup@redbridge.cc.

14.5 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 Pre-authorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

14.6 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 emailing Redbridge customer service at amgroup@redbridge.cc.

14.7 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 emailing Redbridge customer service at amgroup@redbridge.cc. 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.

14.8 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.

15. OTHER BENEFITS

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

15.2 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 is 12 visits per policy year.

15.3 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.

15.4 Hospice Care
Benefits are provided for Hospice approved by the Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill refers to the patient having a prognosis of 240 days or less. Covered services are available in home, Outpatient, and Inpatient settings. The Hospice care:
Must relate to a medical condition that has been the subject of a prior valid claim with the Insurer, with a diagnosis of terminal Illness from a Physician, and
Benefit is payable only in relation to care received by a recognized hospice.

15.5 HIV+, AIDS, ARC
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) only if caused by and accident or blood transfusion, provided the conditions are not considered Pre-existing conditions. Sexually transmitted diseases and all related conditions are not covered.

15.6 Diabetic Supplies
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.

15.7 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 an 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 Policy will be paid at 50% of the allowable Reasonable and Customary amount.

Durable Medical Equipment does not include motor driven wheelchairs or bed; more wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or
temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercycles, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items or the cost of instructions for the use and care of any Durable Medical Equipment. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

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.

15.8 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.

15.9 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.
The following activities and sports are excluded:

1. Hazardous or Extreme Sports or activities, professional sports or activities, 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.

16. CLAIMS PROCEDURES

All claims worldwide are subject to Reasonable and Customary charges as determined by the Insurer and are processed in the order in which they are received. For claims payment to be made, claims must be submitted to the Redbridge claims department in a form acceptable to the Insurer.

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

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

16.2 Fraudulent Claims
If any claim under this Policy is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.
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. For claims payment to be made, claims must be submitted in a form acceptable to Insurer.

16.3 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.

16.4 Claim submission / Customer Service
Redbridge
Claims: claimsmiami@redbridge.cc
Customer Service: amgroup@redbridge.cc.
Telephone: 305-709-0561 or toll free: 1-800-791-4531

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

16.6 Status of Claims
To request the status of a claim or have a question about a reimbursement received, please e-mail Redbridge claims department at claimsmiami@redbridge.cc. Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

16.7 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.

16.8 Coordination of Benefits
It is the duty of the Insured Person to inform Insurer of all other coverage. In no event will more than 100% of the Allowable Charge and/ or maximum benefit for the covered services be paid or reimbursed. United States citizens who are eligible for Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the United States.

17. SUBROGATION, REIMBURSMENT 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.

18. COMPLAINTS PROCEDURE

At times, you may have a concern You would like to tell Us about or disagree with a decision made regarding Your coverage. You can make a compliant or file an appeal to get help for Your situation. The following procedures must be followed for a complaint to be reviewed.

The most important factors in getting Your complaint dealt with as quickly and efficiently as possible are:
- Be sure You are talking to the right person; and
- That You are providing the necessary information.

When You Contact Us
Please provide the following information:
- Your name, telephone number, and email address;
- Your policy and/or claim number and the plan of benefits (medical, travel, disability) You are insured for; and
- Please explain clearly and concisely the reason for Your complaint.

Making a Complaint
If Your complaint relates to:
- The sale of the policy that you purchased or any information you were given during the sales process, contact the broker or other intermediary first.
- We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take us longer than this, we will let you know the reasons for the delay and regularly keep you up-to-date with our progress.

19. NOTICE OF PRIVACY PRACTICES

This notice describes how personal information about You may be used and disclosed and how You can get access to this information. Please review it carefully.

The confidentiality of Your personal information is of paramount concern to Us. We maintain records of the services we cover (claims), and We also maintain information about You that We have used for enrolment processing. We use these records to administer Your policy benefits and coverage; We may also use these records to ensure appropriate quality of services provided to You and to enhance the overall quality of Our services, and to meet Our legal obligations. We consider this information, and the records We maintain, to be protected personal information. We are required by law to maintain the privacy of personal information and to provide Our insureds with notice of Our legal duties and privacy practices with respect to personal information. This notice describes how We may use and disclose Your personal information. It also describes Your rights and Our legal obligations with respect to Your personal information

How We May Use or Disclose Your Personal Information
We collect and process Your personal information as necessary for performance under Your insurance policy or complying with Our legal obligations, or otherwise in Our legitimate interests in managing Our business and providing Our products and services. These activities may include:

- Use of sensitive information about the health or vulnerability of You, or others involved in Your assistance guarantees, to provide the services described in Your insurance policy.
- Disclosure of personal information about You and Your insurance cover to companies within Spectrum Life Ltd. (subject to local laws within each applicable jurisdiction), to Our service Providers and agents to administer and service Your insurance cover, for fraud prevention, to collect payments, and otherwise as required or permitted by applicable law;
- Monitoring and/or recording of Your telephone calls in relation to coverage for the purposes of record-keeping, training and quality control.
- Technical studies to analyze claims and premiums, adapt pricing, support subscription processes and consolidate financial reporting (including regulatory); detailed analyses on claims/calls to better monitor Providers and operations; analyses of customer satisfaction and construction of customer segments to better adapt products to market needs.
- Obtaining and storing any relevant and appropriate supporting evidence for Your claim, for the purpose of providing services under Your insurance policy and validating Your claims; and
- Sending feedback requests or surveys relating to Our services, and other customer care communications.

You are entitled, on request, to a copy of the personal information We hold about You, and You have other rights in relation to how We use Your data (as set out in Our website privacy policy). Please let Us know if You think any information, We hold about You is inaccurate, so that We may correct it.

If You have any questions about this Notice of Privacy Practices or Our use of Your personal information You may contact the Data Protection Officer. Contact details are below:

Spectrum Life Ltd. c/o Spectrum Benefits
2332 Galiano Street, 2nd Floor
Coral Gables, FL 33134

Or

Info@spectrumbenefitsinc.com

20. EXCLUSIONS

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 Reduction:** 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. 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 shownon 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. **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).
24. **Sleep Studies:** Sleep studies and other treatments relating to sleep apnea.
25. **Smoking Cessation:** Treatments and other expenses, whether or not recommended by a Physician.
26. **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.
27. **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.
28. **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.
29. **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.
30. **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.
31. **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) AD&D benefits are not payable for any conditions as a result of self-inflicted Illnesses or injuries, suicide or attempted suicide, while sane or insane. b) AD&D benefits are not payable 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.

21. DEFINITIONS

Accident: Any sudden and unforeseen event occurring during the Policy Year, resulting in bodily Injury, the cause or one of the causes of which is external to the Insured Person's own body and occurs beyond the Insured Person's control.

Actively-at-Work: An Employee will be considered Actively-at-Work if they are performing the regular duties of their occupation on the date the insurance Policy takes effect.

Activities of Daily Living (ADL): Those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/feeding, medication, and getting in and out of bed.

Acupuncture: Treatment of a medical condition, which is covered under the terms of this Policy, by needles or laser provided by or ordered by a licensed Physician as defined in this Policy.

Acute Care: Medically Necessary, short-term care for an Illness or Injury, characterized by rapid onset, severe symptoms, and brief duration, including any intense symptoms, such as severe pain.

Admission: The period from the time that an Insured Person enters a Hospital, Extended Care Facility, or other approved medical care facility as an Inpatient until discharge.

Air Ambulance: An aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life- threatening Illnesses and/or Injuries for persons whose conditions cannot be treated locally and must be transported by air to the nearest medical center that can adequately treat their conditions. This service requires Pre-Authorization. A commercial passenger airplane does not qualify as an Air Ambulance.

Allowable Charge: The fee or price Insurer determines to be the Reasonable and Customary Charge for medical care services provided to Insured Persons that are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge (except in the U.S. when a Preferred Provider has delivered the service, then there is no balance due). All services must be Medically Necessary. Once an allowable charge is established then the Deductible, Coinsurance, Copayments and any excess charges must be paid by the Insured Person.

Ambulatory Surgical Center: A facility which (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a hospital. Ambulatory Surgical Center: does not include (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a dentist for the practice of dentistry.

Annual Maximum Benefit: The payment specified in the Schedule of Benefits, for specific services, which is the maximum amount payable by Insurer per person, per Policy Year regardless of the actual or Allowable Charge. This is after the Insured Person has met his obligations of Deductible, Coinsurance, Copayments and any other applicable costs.

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

Coinsurance: The percentage amount of the Allowable Charges that the Insured Person and the Insurer will share after the Deductible is met.

Company: Spectrum Life Ltd. hereinafter referred to as We, Us and Our.

Complications of Maternity and Perinatal: A condition:

- Caused by pregnancy, and
- Requiring medical treatment prior to, or after termination of pregnancy, and
- The diagnosis of which is distinct for pregnancy, and
- Causes complications in the newborn unrelated to Congenital or Hereditary Conditions.

A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

Confinement: Inpatient stay at an approved Extended Care Facility for necessary skilled treatment or rehabilitation in accordance with the contract.

Congenital Condition: Any heredity condition, birth defect, physical anomaly and/or any other deviation from normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Copayment: A fixed dollar amount that may be applied per office visit each time medical services are received. Ancillary services such as laboratory and radiology service (i.e. blood tests, x-rays) that may be in conjunction with an office visit do not require a separate Copayment. Copayments do not apply to the Deductible or to the Out-Of-Pocket Maximum.

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 Expenses: The Reasonable and Customary charges incurred by an Insured Person, while covered under this Policy, for Medically Necessary services, treatments or supplies described under the provisions titled Medical Coverage and, if applicable, covered dental expense and/or covered vision expense.

Covered Pregnancy is all that;

a)Whose delivery date is at least 10 months after the Effective Date of coverage for the Insured mother, and
b)Conception did not occur due to any fertility/infertility treatment or any assisted medical treatments or procedures, and
c)Maternity coverage is included under the Policy, and
d)The Insured meets the eligibility criteria for maternity related services.

Note: The acquisition of the Maternity and Perinatal Complications Rider does not qualify for a Covered Pregnancy.

Custodial Care: Includes: 1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and 2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and 3) rest cures, respite care and home care provided by family members. Upon receipt and

review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

Deductible: The amounts of covered Allowable Charges payable by the Insured Person during each Policy Period before the Policy benefits are activated. Such amount will not be reimbursed under the Policy. The Deductible is not considered part of the annual Out-of- Pocket Maximum.

Dependent: Refers to a member of the Insured Person's family who is enrolled under the Policy with the Insurer after meeting all the eligibility requirements and for whom Premiums have been received.

Durable Medical Equipment (DME): Orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an Illness or Injury and determined by Insurer on a case by case basis to be Medically Necessary including motorized wheelchairs and beds. See DME Section for more details and services that are not considered eligible benefits.

Effective Date: The date upon which an Insured Person's coverage will commence under this Policy, as determined by the Insurer.

Eligibility: The requirements that an Insured Person must meet at all times in order to be covered under this employer group Policy.

Emergency: A sudden or unexpected onset of a condition requiring medical or surgical care which the Insured Person secures after the onset of such condition, or soon thereafter as care can be made available, but in any case, not any later than 24 hours after the onset and in the absence of which care an Insured Person would be expected to suffer serious bodily Injury or death.

Emergency Dental Treatment: Emergency dental treatment is urgent treatment necessary to restore or replace sound natural teeth damaged as a result of an Accident. Sound teeth do not include teeth with previous crowns, fillings, or cracks. Damage to teeth caused by chewing foods does not qualify for Emergency Dental Coverage.

Emergency Treatment: Medical care for a Medical Emergency that is required for the immediate relief of an acute symptom or upon advice from a licensed physician cannot be delayed until your return to your Home Country.

Experimental and/or Investigational: Any treatment, procedure, technology, facility, equipment, medication, medication usage, device, or supplies not recognized as accepted medical practice by the Insurer.

Extended Care Facility: A nursing and/or rehabilitation center approved by the Insurer that provides skilled and rehabilitation services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of substance abuse addicts or alcoholics, or similar institutions.

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.

HIV: All diseases caused by and/or related to the HIV Virus including Acquired Immune Deficiency Syndrome (AIDS).

Home Country: The country from which the Insured Person holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country.

Homeopathy: A system of alternative medicine that seeks to treat patients by administering small doses of medicines that would bring on symptoms similar to those of the patient in a healthy person. For example, the Homeopathic treatment for diarrhea would be a miniscule amount of a laxative.

Home Health Care Agency: An agency or organization, or subdivision thereof, that; a) is primarily engaged in providing skilled nursing services and other therapeutic services in the Insured Person's home, b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate nurse (R.N.), to govern the services provided, d) provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.), e) maintains a complete medical record on each patient, and f) has a full-time administrator.

Home Health Care: A program: 1) for the care and treatment of an Insured Person in his home; 2) established and approved in writing by his attending Physician; and 3) Certified, by the attending Physician, as required for the proper treatment of the Illness or Injury, in place of Inpatient treatment in a Hospital or in an Extended Care Facility.

Hospice: An agency which provides a coordinated plan of home and Inpatient care to a terminally ill person and which meets all of the following tests: 1) has obtained any required state or governmental license or Certificate of Need; 2) provides service 24 hours a day, 7 days a week; 3) is under the direct supervision of a Physician; 4) has a nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); 5) has a duly licensed social service coordinator; 6) has as its primary purpose the provision of Hospice services; 7) has a full-time administrator; and 8) maintains written records of services provided to the patient.

Hospital: Acute care facilities licensed or approved by the appropriate regulatory agency as a Hospital, and whose services are under the supervision of, or rendered by a staff of Physicians who are duly licensed to practice medicine, and which continuously provides 24 hour a day nursing service under the direction or supervision of registered professional nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, custodial care, care of substance abuse addicts or alcoholics, or similar institutions.

Injury: Bodily harm resulting, directly and independently of any Illness and which is caused by, arises out of, or results from an Accident or the sudden onset of physical trauma. All injuries sustained in any one Accident, including all related conditions and recurring symptoms, will be considered as one Accident.

Illness: A physical sickness, disease, pregnancy and complications of pregnancy of an Insured Person. This does not include mental Illness.

Inpatient: A person admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

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.

Insured Person/Insured: An Employee or Dependent enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.
In-Network Providers: Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Insurer: Spectrum Life Ltd.

Late Enrollee: An Insured Person who enrolls for coverage more than 31 days after the date of eligibility.

Lifetime Maximum: The maximum amount payable by the Insurer per individual Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force.

Mandatory Plan: All employees that meet the Eligibility definition are required to enroll under this Policy. A waiver of coverage is not permitted.
Medical Identification Card: The card provided to each Insured Person. This card contains limited benefit information, as well as contact information for submitting claims and emergency medical treatment. Insureds may in certain circumstances have two identification cards.

Medical Emergency: A sudden, unexpected, and unforeseen event caused by an Illness or Injury that manifests itself by symptoms of sufficient severity that a prudent layperson would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

Medically Necessary: Those services or supplies which are provided by Hospital, Physician or other approved medical Providers that are required to identify or treat an Illness or Injury and which, as determined by Insurer, are as follows:

- Consistent with the symptom, or diagnosis and treatment of condition, disease or Injury, and
- Appropriate with regard to standards of accepted professional practice, and
- Not solely for the Insured Person's convenience, the Insured's family convenience, the Physician's convenience or any other Provider's convenience, and
- The most appropriate supply or level of service, which can be provided. When applied to an Inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an Outpatient, and
- Follow the standard of practice, as established by the professional councils of its field (medicine, physiotherapy, nursing, etc.)
- Is not a part of or associated with the scholastic education or vocational training of the patient, and
- Is not experimental or investigative.
- Does not Exceed the level of care required to allow diagnosis and appropriate treatment.

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).

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."

Nurse: A person licensed as a Registered Nurse, (R.N.) or Licensed Practical Nurse, (L.P.N.) by the appropriate licensing authority in the areas which he practices nursing.

Organ Transplant: Removing 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.

Outpatient: Services, supplies or equipment received while not an Inpatient in a hospital, or other medical care facility, or overnight stay. Outpatient surgery is inclusive of all invasive procedures including colonoscopy and endoscopy procedures.

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 Maximum: The maximum amount of expenses the Insured Person will pay for Allowable Charges during the Policy Year after the Deductible is met.

- Once the Policy Year Coinsurance maximum is reached, the Insurer shall pay 100% of eligible Covered Expenses for the remainder of the Policy Year.
- The Coinsurance maximum does not include any of the expenses covered under the optional dental or vision benefits.

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: Any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he practices medicine, osteopathy or podiatry and who is acting within the scope of that license. This term does not include: (1) an intern, or (2) a person in training.

Policy: The agreement between the Insurer and the Participating Organization. The Policy includes this document, Schedule of Benefits, the application, any medical questionnaires, the last issued identification card, and any riders made in accordance with the Policy.

Policy Effective Date: The date that this Policy is first implemented, without regard to renewals thereafter. Policy Face Page: The Policy schedule of benefits, which includes information about Insureds, Deductible, Premium, exclusions or additional restrictions, product and coverage.

Policy Period (or Policy Year): The dates as shown on the Policy Face Page for which Premium has been paid.

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 process by which an Insured Person obtains written approval for certain medical procedures or treatments from the Insurer prior to the commencement of the proposed medical treatment. Certain medical procedures will require the Pre- Authorization process to be followed in order for the service to be covered and to maximize the benefits of the Insured Person.

Pre-Existing Condition: Any Illness or Injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed medication, or where distinct symptoms were evident prior to the Effective Date. Please refer to your Schedule of Benefits for any limitations, restrictions or requirements related to coverage of pre-existing conditions.

Preferred Allowance: Refers to the amount an In-Network Provider will accept as payment in full for covered medical expenses.

Preferred Provider: Refers to a participating Provider, such as Hospital, clinic or Physician that has entered into an agreement to provide medical services to persons insured by the Insurer.
Premium: The consideration owed to the Insurer in order to secure benefits for its Insured Students under this Policy.

Prescription Drugs/Medications: Are medications which are prescribed by a Physician and which would not be available without such prescription. Certain treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, experimental or Investigative medications, or medical supplies even when recommended by a Physician, do not qualify as Prescription Medications.

Professional Sports: Activities in which the participants receive payment for participation.
Provider: The organization or person performing or supplying treatment, services, supplies or medications.

Rehabilitation: Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery.

Repatriation or Local Burial: This is the expense of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to their Home Country, or the preparation and local burial of the mortal remains of an Insured Person who dies outside their Home Country. This benefit is excluded where death occurs in their Home Country.

Respite Care: Inpatient care for a chronically or terminally ill patient, for the sole purpose of relieving the patient's primary caregiver.

Schedule of Benefits: The summary description of the benefits purchased by the employer, payment levels and maximum benefits, provided under this Policy. The Schedule of Benefits is part of this Policy.

Serious Accident: An Accident that requires immediate hospitalization for at least 24 hours. Medical necessity will be assessed by the Insurer.

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 Physician who has completed advanced education and clinical training in a specific area of medicine.

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.

Subrogation: The term subrogation refers to circumstances under which the Insurer may recover expenses for a claim paid out when another party should have been responsible for paying all, or a portion of that claim.

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).

Terrorism: Terrorist activity means an act, or acts, of any person, or groups of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear.

Terrorist activity can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization or government.

Usual, Customary and Reasonable (UCR): The lower of :1) the Provider's usual charge for furnishing the treatment, service or supply; or 2) the charge determined by the Insurer to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: 1) who reside in the same geographical area; and 2) whose Illness or Injury is comparable in nature and severity.

The UCR charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Insurer. The Insurer will consider such factors as: 1) complexity, 2) degree of skill needed, 3) type of Specialist required, 4) range of services or supplies provided by a facility, and 5) the prevailing charge in other areas.

Urgent Care Center: a walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional hospital-based or freestanding emergency department (ED). Other names for similar types of facilities include, but are not limited to, after-hours walk-in clinics, minute clinics, quick care clinics, convenience clinics, minor emergency centers, and minor care clinics.

Waiting Period: The period of time beginning with the Insured Person's Effective Date, during which limited, or no benefits are available for particular services. After satisfaction of the Waiting Period, benefits for those services become available in accordance with this Policy.