Benefit Re

2026-2027

Essential Health Plan

500

700 Plantation Island Dr S Ste 101, St. Augustine, FL 32080, USA

Underwritten by: Benefit Re (NAIC 17459)

ACA compliant,
US based health plan



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Important notice

Coverage Area: USA. This plan is not an international plan. This Policy is designed to provide health care coverage in the United States. The benefits and services described in your Policy have an unlimited annual maximum and include all Essential Health Benefits.

Eligibility

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

Are properly enrolled in the plan, and Pay the required premium.

Except in the case of a waiver denial or withdrawal from School due to Sickness or Injury, any student who withdraws from the Policyholder's School during the first 31 days of the period for which he or she is enrolled shall not be covered under the insurance plan. A full refund of Premium will be made, minus the cost of any claim benefits paid by the Certificate. A student who graduates or withdraws after such 31 days of the period for which he or she is enrolled will remain covered under this Certificate for the term purchased and no refund will be allowed. We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been and continue to be met. If we discover that the Certificate eligibility requirements have not been met, our only obligation is refund of Premium less any claims paid. Eligibility requirements must be met each time Premium is paid to continue coverage.

If the Insured Student or the Insured Student's Dependent has performed an act that constitutes fraud; or the Insured Student has made an intentional misrepresentation of material fact during enrollment in 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.

Who is Eligible:

- **Class 1**: All registered full-time students enrolled in an accredited institution of higher education in an associate's, bachelor's, master's, or doctoral degree program. This does not apply to students in their final term, or to part-time students who are prospective graduates.
- **Class 2**: The Spouse of a Class 1 Insured Person
- **Class 3**: The dependent child(ren) of a Class 1 Insured Person

Who Is Not Eligible: Students enrolled in distance learning or home study programs, and students on OPT (Optional Practical Training) status.

Essential 500 Schedule of Benefits

Annual Deductible		
	In-Network (Participating)	**Out-of-Network (Non-Participating)**
Individual	$500	$1,500
Family	$1,000	$3,000

Out-of-Pocket Maximum		
	In-Network (Participating)	**Out-of-Network (Non-Participating)**
Individual	$10,600	$20,000
Family	$21,200	$40,000

Coinsurance (After Deductible)		
Member Pays	20% (Member Coinsurance after Deductible)	40% (Member Coinsurance after Deductible, UCR)
Coinsurance at Student Health Center	Covered in Full (100%)	Not Applicable
Overall Policy Maximum Benefit	No Limit	No Limit

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Preventive Care Services			
Routine Physical Exam (see Preventive Care Guide)	No	Covered in Full (No Copay)	No Benefit
Routine Care Immunizations (see CDC Guideline)	No	Covered in Full (No Copay)	40% Coinsurance after Ded. (UCR)
Tuberculosis Screening (TB), Titers, QuantiFERON B	No	Covered in Full (No Copay)	Not Covered
Emergency Services | Any provider may be used for a true emergency, no penalty			

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Emergency Room Facility & Services (non-emergency reduced 50%; waived if admitted)	No	$250 Copay + 20% Coinsurance after Ded.	$250 Copay + 20% Coinsurance after Ded.
Emergency Ambulance (Ground/Air/Water)	No	20% Coinsurance after Ded.	20% Coinsurance after Ded.
Urgent Care Center	No	$50 Copay + 20% Coinsurance after Ded.	$50 Copay + 40% Coinsurance after Ded. (UCR)
Non-Emergency Ambulance Expense (Ground Transportation Only)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Inpatient Hospital Services			
Room and Board	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Intensive Care	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Hospital Miscellaneous Expenses	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Surgery | Surgeon, Anesthetist & Assistant Surgeon	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Registered Nurse's Services	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Skilled Nursing Facility Benefits	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Preadmission Test	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Organ Transplant	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Mental Health & Substance Use Disorder			
Inpatient Mental Health & Substance Use Disorder	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Outpatient Mental Health & Substance Use Disorder	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Outpatient Services			
Outpatient Surgery | Surgeon, Assistant & Anesthetist	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Physical Therapy (Outpatient Office Visit)	Yes	$20 Copay + 20% Coinsurance after Ded.	$20 Copay + 40% Coinsurance after Ded. (UCR)
Dental Treatment | Injury to Sound, Natural Teeth; Surgical Removal of Impacted Teeth	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Vision Care Services | Annual Retina Exam (Glaucoma/Diabetic Retinopathy)	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Office Visits			
Telehealth or Telemedicine	No	Covered in Full (No Copay, No Deductible)	Not Applicable
Physician's Office Visit | Including Specialist	No	$25 Copay + 20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Allergy Test and Treatment	No	$25 Copay + 20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Chiropractic Care (12 visits/policy year; pre-authorization required after visit 6)	Yes, after visit 6	$25 Copay + 20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Diagnostic Lab, Test and Imaging Services			
Lab Test, X-Ray & Other Tests	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Advanced Imaging Services (CT, MRI and/or PET)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Chemotherapy and Radiation Therapy	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Infusion Therapy	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Maternity and Newborn Care			
Newborn Care	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Maternity	No	20% Coinsurance after Ded. Routine prenatal preventative office visit - No charge	40% Coinsurance after Ded. (UCR)
Complication of Pregnancy	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Abortion	No	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Rehabilitative and Habilitative Services			
Cardiac Rehabilitation	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Pulmonary Rehabilitation	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Inpatient Rehabilitation Facility Expense Benefit	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Rehabilitation Therapy | PT, OT & Speech (12 visits/plan year, combined w/ Habilitation)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Habilitation Services | PT, OT & Speech (12 visits/plan year, combined w/ Rehab Therapy)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Other Covered Services			
Alternative Medicine | Acupuncture, Homeopathy, Chinese Medicine (6 visits/yr)	No	20% Coinsurance after Ded.	Not Available
Home Health Care (12 visits/plan year)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Prosthetic and Orthotic Devices	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Hospice	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Diabetic Services & Supplies (Equipment & Training)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Dialysis	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Durable Medical Equipment (Limited to one durable medical equipment for same/similar purpose; excludes repairs for misuse/abuse.)	Yes	20% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Pediatric Dental and Vision Care Services			
Pediatric Dental Care Benefit | Emergency, Endodontic, Prosthodontic & Necessary Orthodontic Care (through age 19)	No	50% Coinsurance (UCR)	50% Coinsurance (UCR)
Pediatric Dental Preventive Care | 2 Exams/12 Months (Cleaning, Fluoride, X-ray, Space Maintainers)	No	Covered in Full (UCR)	Covered in Full (UCR)
Pediatric Vision Care Benefit | 1 Exam Covered in Full & 1 Pair of Frames or Contacts Covered in Full up to a $150 Maximum Benefit per Policy Year (through age 19)	No	Covered in Full; Frames/Contacts up to $150 Max Benefit (UCR)	No Benefit
Evacuation and Repatriation			
Medical Evacuation	Yes	Paid in Full to $100,000/Person, per Benefit Period	Paid in Full to $100,000/Person, per Benefit Period
Medical Repatriation	Yes	Paid in Full to $50,000 Lifetime/Person	Paid in Full to $50,000 Lifetime/Person

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Repatriation of Mortal Remains	Yes	Paid in Full to $25,000	Paid in Full to $25,000

Drug Tier	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Retail Pharmacy — 30-day supply (must be on the plan formulary)			
Tier 1 — Preventive / Generic Rx (30-day supply only, on plan formulary)	No	**$15 Copay**	**50% Coinsurance after $15 Copay**
Tier 2 — Preferred Brand Rx (30-day supply only, on plan formulary)	No	**30% Coinsurance per Prescription**	**50% Coinsurance after $20 Copay**
Tier 3 — Non-Preferred Brand Rx (30-day supply only; Prior Authorization may apply above $300)	May apply (above $300)	**40% Coinsurance per Prescription**	**50% Coinsurance after $70 Copay**
Tier 4 — Specialty Rx (30-day supply only; Prior Authorization may apply above $300)	May apply (above $300)	**50% Coinsurance per Prescription**	**50% Coinsurance after $100 Copay**

Coverage Area

USA only. This plan is not an international plan.

Effective and Termination Dates

Effective dates: The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2026. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

Termination Dates: The Master Policy terminates at 11:59 p.m., July 31, 2027. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student. The Master Policy is a non-renewable 1-year term insurance policy.

Extension of the Benefits: The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date. The total payments made in respect of the Insured for such conditions both before and after the Termination Date will never exceed the maximum benefit. After this Extension of Benefits provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Grace Period: Coverage may begin up to thirty (30) days before the program start date, or continue up to thirty (30) days after the program end date, for an Insured Person entering or remaining in the United States during that time (subject to a maximum insurance period of 365 days).

Preferred Provider and Out-of Network Provider

This plan is a preferred provider organization or “PPO” plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan’s network of Preferred Providers. The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as Out-of-Network Providers. However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost. If you use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits. If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by us will be your responsibility.

Please contact our Customer Service area with any questions about In-Network Provider availability at the number on your ID card. You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that you verify that your Physicians are In-Network Providers each time you call for an appointment or at the time of service.

Pre-Authorization

In-Network: your In-Network Provider is responsible for obtaining any necessary Pre-authorization before you receive the care. If your In-Network Provider does not obtain the required Pre-authorization you will not be penalized. Please read below regarding review and notification.

Out-of-Network: you or your Out-of-Network Provider are responsible for calling us at the phone number found on your ID card and starting the Pre-authorization process. For Inpatient services, the call must be made at least 5 working days prior to Hospital Confinement. For Outpatient services, the call must be made at least 3 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

Pre-notification of Medical Non-emergency Hospitalization: Patient, Physician or Hospital should telephone +1.915.803.4198 at least five business days prior to the planned admission.

Notification of Medical Emergency Authorization: Patient, Physician or Hospital should call +1.915.803.4198 within two business days of the hospitalization to provide notification of any medical emergency.

The following Inpatient and Outpatient services require Pre-authorization:

1. Ambulance Service for non-emergency (ground transportation only)
2. In-Patient

- Room and Board
- Intensive Care
- Surgery including Anesthetist and Assistant Surgeon
- Registered Nurse's Services
- Skilled Nursing Facility
- Organ Transplant

3. Mental Health Disorder and Substance Disorder

- Inpatient Mental Health Disorder and Substance Use Disorder

4. Out-Patient

- Physical Therapy

5. Office Visits

- Chiropractic Care

6. Diagnostic Lab, Test and Image Services

- Advanced Imaging Services (CT, MRI or PET)
- Infusion Therapy

7. Rehabilitative and Habilitative Services

- Cardiac Rehabilitation

- Pulmonary Rehabilitation
- Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy
- Habilitation Services including, Physical Therapy, and Occupational Therapy and Speech Therapy

8. Other Services

- Durable Medical Equipment
- Home Health Care
- Prosthetic and Orthotic Devices
- Hospice
- Diabetic Services and Supplies
- Dialysis

Pre-authorization is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48/96 hours of maternity care.

Mental Health Parity Safeguard

Any Pre-authorization or other nonquantitative treatment limitation applied to Mental Health or Substance Use Disorder benefits will comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), as applicable. The processes, strategies, evidentiary standards, and other factors used will be comparable to, and applied no more stringently than, those used for Medical/Surgical benefits in the same classification. No separate or more restrictive Pre-authorization requirement will apply solely because a service is a Mental Health or Substance Use Disorder service.

Federal Surprise Billing Protections

The Plan will comply with the No Surprises Act and applicable state surprise-billing laws. Emergency Services will not require prior authorization. For protected Emergency Services, covered air ambulance services, and protected non-emergency services furnished by Out-of-Network Providers at In-Network facilities, cost-sharing will be determined and accumulated toward the In-Network Deductible and Out-of-Pocket Maximum as required by law, and prohibited balance billing will not be permitted. Emergency status will be determined under the prudent layperson standard and not solely by the final diagnosis. Post-stabilization services remain protected unless a lawful exception applies.

Pre-authorization is not a guarantee that benefits will be paid.

Your Physician will be notified of our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, we will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of our decision in writing or by telephone;
3. For any other covered services requiring Pre-authorization, we will contact the Provider in writing or by telephone regarding our decision.

Our agent will make this determination within 24 hours for an urgent request (including urgent requests involving inpatient or outpatient Mental Health Disorders and Substance Use Disorders), and within 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by our agent will be in writing or electronic means and will include:

1. Information sufficient to identify the claim involved in the grievance, including the date of service, if applicable, the health care professional and the claim amount.
2. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
3. Reference to the evidence or documentation used as the basis for the decision.
4. A description of any additional material or information the Insured Person may need to submit to assist in the review process.
5. A description of our internal review process that includes (a) our expedited review procedures, (b) any time limits applicable to such process or procedure, (c) our contact information for organizational unit designated to coordinate the review on our behalf, and (d) a statement that the Insured Person is entitled to (1) submit written comments, documents, records, and other material relating to the Insured Person's request for consideration by the individual or individuals conducting the review, and (2) receive from us, free of charge upon request, reasonable access to and copies of all documents, records and other information relevant to the request.
6. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;

If the Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;

1. Instructions for requesting: (1) a copy of the rule, guideline, protocol, or other similar criterion relied upon to make the final determination; and (2) the written statement of the scientific or clinical rationale for the determination;
2. Instructions on how to initiate standard or urgent Appeal.
3. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
4. Notice of the Insured Person's right to to initiate an Appeal. If you have any questions about your Pre-authorization status, you should contact your Provider.

Medical Expense Benefits

This section describes Covered Medical Expenses for which benefits are available. Please refer to the attached Schedule of Benefits for benefit details. Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the Definitions section and the Exclusions and Limitations section carefully. Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section. No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in Exclusions and Limitations. If a benefit is designated, Covered Medical Expenses include:

Preventive Care

The following services shall be covered without regard to any Deductible, Coinsurance, or Copayment requirement that would otherwise apply when provided by an In-Network Provider:

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

Important Notes:

1. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.
2. Diagnostic testing for the Treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, you will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
3. This plan will not limit gender-specific Preventive Services based on your gender at birth, your identity, or according to other records. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your Physician or contact us by calling the number on your ID card. This information can also be found at the https://www.healthcare.gov/ website. We may use reasonable medical management techniques to determine the frequency, method, Treatment, or setting of Preventive Services benefits when not specified in the recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration (HRSA)
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Emergency Services

Emergency Room: Benefits will be paid for the use of a Hospital emergency department or independent free-standing emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after you are moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after you are Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished.

Emergency Ambulance: with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to your home is not covered.

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

Non-Emergency Ambulance Expense: Expenses for Medically Necessary ground transportation only by a licensed Ambulance (air and water ambulance are not covered under this benefit). Pre-authorization is required. Benefits are payable when the transportation is:

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

Inpatient

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

Intensive Care: See Schedule of Benefits.

Hospital Miscellaneous Expenses: When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.

- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

Surgery: Physician's fees for Inpatient surgery.

Assistant Surgeon Fees: Assistant Surgeon Fees in connection with Inpatient surgery.

Anesthetist Services: Professional services administered in connection with Inpatient surgery.

Registered Nurse's Services: Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity. General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.

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

Pre-admission Testing: Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

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

Mental Health Disorder and Substance Use Disorder

1. Inpatient and Outpatient Mental Health Disorder Benefit for Treatment of Mental Health Disorders as specified on the Schedule of Benefits. Coverage also includes two mental health wellness examinations per Policy Year when performed by a licensed mental health professional. We will also pay the expenses incurred for the diagnosis and Treatment of Autism Spectrum Disorder. We will provide coverage for the following Medically Necessary Treatments, provided such Treatments are identified and ordered by a Physician, licensed psychologist or licensed clinical social worker for an Insured Person who is diagnosed with an Autism Spectrum Disorder, in accordance with a Treatment plan developed by a Physician, licensed behavior analyst, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the Insured Person: a. Behavioral Therapy; b. Prescription drugs, to the extent prescription drugs are a covered benefit for other Covered Sicknesses, prescribed by a Physician, licensed Physician assistant or advanced practice registered nurse for the Treatment of symptoms and comorbidities of Autism Spectrum Disorder;

- Direct psychiatric or consultative services provided by a licensed psychiatrist;
- Direct psychological or consultative services provided by a licensed psychologist;

- Physical therapy provided by a licensed physical therapist;
- Speech and language pathology services provided by a licensed speech and language pathologist; and
- 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.

1. Inpatient and Outpatient Substance Use Disorder Benefit for Treatment of Substance Use Disorders as specified on the Schedule of Benefits. We will also pay the expenses incurred due to Medically Necessary inpatient and outpatient emergency medical care arising from accidental ingestion or consumption of a controlled drug.

Outpatient

Outpatient Surgery: Physician's fees for Outpatient surgery. It is recommended that Outpatient Surgery be performed in an In-Network free-standing facility to maximize your benefit and reduce your costs.

Physical Therapy must be provided by a licensed therapist.

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

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

Office Visits

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.

Physician's Office Visit: Physician's Visits include second surgical opinions, specialists, and consultant services. Benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

Allergy Test and Treatment: This includes tests that you need such as PRIST, RAST, and scratch tests. Also includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications, and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, allergy serum, and supplies used for allergy therapy.

Chiropractic Care: Treatment of a Covered Injury or Covered Sickness performed by a Physician, limited to 12 visits per Policy year. Pre-authorization is required for visits 7 through 12.

Tuberculosis Screening (TB), Titers, and QuantiFERON B tests: when required by the School for high risk Insured Persons (other than as covered under Preventive Care Services).

Diagnostic Lab, Testing and Imaging Service

Lab Test, X-Ray and other Tests: diagnostic X-ray services and laboratory procedures, both when prescribed by a Physician. Outpatient: It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free-standing facility to maximize your benefit and reduce your costs.

Chemotherapy and Radiation Therapy: for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness.

Infusion Therapy: for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Advanced Imaging Services (CT Scan, MRI and/or PET Scan): diagnostic services when prescribed by a Physician. Inpatient: services can be allowed in hospital. Outpatient: It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free-standing facility to maximize your benefit and reduce your costs.

Maternity and Newborn Care

Newborn Care: While Hospital Confined and routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

Maternity: Same as any other Sickness for maternity-related services, including prenatal and postnatal care. Benefits will be paid for an inpatient stay of at least:

- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. An earlier discharge may be provided if based on evaluation and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the newborn in the first 48 hours after discharge. A shorter length stay must meet the protocols and guidelines for the length of a Hospital Inpatient stay as developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

Complication of Pregnancy: Same as any other Sickness.

Abortion: Coverage for the expense of an elective, non-therapeutic abortion.

Rehabilitative and Habilitative Services

Cardiac Rehabilitation: Benefits are available for Outpatient cardiac Rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive Rehabilitation phase of the program.

Pulmonary Rehabilitation: Benefits are available for pulmonary Rehabilitation services as part of an inpatient Hospital stay if it is part of a treatment plan ordered by a Physician. A course of outpatient pulmonary

Rehabilitation may also be eligible for coverage if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by a Physician.

Inpatient Rehabilitation Facility Expense: Benefit for the services, supplies and Treatments rendered to you in an Inpatient Rehabilitation Facility. You must enter an Inpatient Rehabilitation Facility:

- After being discharged from a Hospital Confinement for a Covered Sickness or Coverage Injury; and
- Rehabilitation Therapy when prescribed by the attending Physician, or an advanced practice registered nurse, limited to 1 visit per day, 12 visits per Policy year, combined with Habilitation Services. Habilitation Services when prescribed by the attending Physician, or an advanced practice registered nurse, limited to 1 visit per day, 12 visits per Policy year, combined with Rehabilitation Therapy.

Prescription Drugs

medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-authorization. These prescription requirements help your prescriber and pharmacists check that your outpatient Prescription Drug is clinically appropriate using evidence-based criteria. Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands. Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth. You're covered for all types of medicine, from less to more expensive: Tier 1 (Generic) is the lowest cost; Tier 2 (Brand) is a slightly higher cost; Tier 3 (Non-Preferred Brand) is a higher cost than Brand; and Tier 4 (Preferred Specialty) is the highest cost.

Dispense as Written

If a prescriber specifies "Dispense as Written" (DAW), or determines that the covered Brand-Name Prescription Drug is Medically Necessary because the Generic equivalent is not medically appropriate, you will pay the applicable Brand-Name cost sharing. Such covered cost sharing will apply toward your Deductible and Out-of-Pocket Maximum as required by applicable law. If a Generic equivalent is available and medically appropriate, the prescriber does not specify DAW, and you voluntarily request the Brand-Name Prescription Drug, you may be responsible for the difference in cost between the Brand-Name Prescription Drug and the Generic equivalent, in addition to the applicable Brand-Name cost sharing. Only the additional amount attributable to your voluntary selection of the Brand-Name Prescription Drug may be excluded from the Deductible or Out-of-Pocket Maximum, and only to the extent permitted by applicable law.

Off-Label Drug Treatment: When Prescription Drugs are provided as a benefit under this Certificate, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met: -The drug is approved by the FDA; -The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS; -The drug has been recognized for Treatment of that condition by a nationally recognized drug database or two separate articles in major peer reviewed medical journals/clinical practice guidelines (cancer indications will only require evidence from ONE article or clinical

practice guideline). When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to us documentation supporting compliance with the requirements of this benefit. As it pertains to this benefit, life threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
- Diseases or conditions with a potentially fatal outcome, where the endpoint of clinical intervention is survival

Supply 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. This plan does not provide benefits for a Prescription Drug supply greater than 30 days at one time. Certain Prescription Drugs, including higher-cost drugs, may require Pre-authorization based on the Plan's formulary, clinical criteria, and utilization management requirements. No fixed monetary penalty applies solely because a prescription's cost exceeds $300.

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

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

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

1. Diabetic supplies The following diabetic supplies may be obtained under your Prescription Drug benefit upon prescription by a Physician: Insulin

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

You can identify covered diabetic supplies by referring to the Formulary posted on our website at www.benefitreinsurance.com or by calling the toll-free number on your ID card. Refer to the Diabetic

Services and Supplies (including equipment and training) provision for diabetic services and supplies covered under the Diabetic Services and Supplies (including equipment and training) benefit.

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

Other Services

Alternative Medicine (Acupuncture, Homeopathy, or Chinese Medicine): is covered up to a maximum of 6 visits per Policy year.

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.
- Home Health Care is limited to 12 visits per Policy year.

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 teaching and monitoring of complex care skills such as 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.

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.

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

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

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.

Dialysis: To treat an acute or chronic kidney ailment, provided in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in your home. In the case of a chronic kidney ailment, this treatment is allowed only at a free-standing facility. Covered Medical Expenses for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

Durable Medical Equipment: for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheelchairs, walkers, braces, ostomy supplies and appliances, that stabilize an injured body part and braces to treat curvature of the spine. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:

- Be primarily and customarily used to serve a medical, rehabilitative purpose;
- Be able to withstand repeated use; and
- Generally, not be useful to a person in the absence of Injury or Sickness. Coverage also includes hypodermic needles and syringes when ordered by your Physician to be used with a covered medication for a Covered Sickness.

Pediatric Dental and Vision Care Services

1. Pediatric Dental Care Benefit

- Preventive Dental Care, that includes procedures which help to prevent oral disease from occurring, including:
- Dental examinations, visits and consultations once within a 6-month consecutive period (when primary teeth erupt);

- X-ray, full mouth x-rays at 36-month intervals, bitewing x-rays at 6 to 12-month intervals, or panoramic x-rays at 36-month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Prophylaxis (scaling and polishing the teeth) at 6-month intervals;
- Topical fluoride application at 6-month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- Emergency Dental care, which includes emergency palliative Treatment required to alleviate pain and suffering caused by dental disease or trauma.
- Routine Dental Care: We cover routine dental care provided in the office of a Dental Provider, including:
- Procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless-steel crowns; and
- Other restorative materials appropriate for children.
- Endodontic Services, including procedures for Treatment of diseased pulp chambers and pulp canals, where hospitalization is not required.
- Prosthodontic Services as follows;
- Removable complete or partial dentures, including 6-month follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate. Fixed bridges are not covered unless they are required:
- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Periodontic Services: include but are not limited to: root planning and scaling at 24-month intervals; gingivectomy at 36-month intervals; gingival flap procedures at 36-month intervals; and osseous surgery (including flap and closure) at 5-year intervals.

Medically Necessary Orthodontic Care: to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to: Rapid Palatal Expansion (RPE); Placement of component parts (e.g. brackets, bands); Interceptive orthodontic Treatment; Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);

- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

Pediatric Vision Care Benefit:

for Insured Persons (through age 19 subject to the termination date provision). We will provide benefits for: 1 vision examination per Policy year, covered in full, and 1 pair of prescribed lenses and frames or contact lenses per Policy year, covered in full up to a maximum benefit of $150.

Medical evacuation and Repatriation

Medical evacuation (International Students and Domestic Students and their Dependents): The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits. If you are unable to continue your academic program as the result of a Covered Injury or Covered Sickness that occurs while you are covered under this Certificate, we will pay the necessary Actual Charges for evacuation to another medical facility or your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits. Payment of this benefit is subject to the following conditions:

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

Repatriation

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

General Exclusions

No benefits will be paid for: a) loss or expense caused by, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Addiction, such as:

- Caffeine addiction.
- Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
- Codependency.

2. Behavioral problems. Developmental delay or disorder or intellectual disability. Learning disabilities. This exclusion does not apply to benefits specifically provided in the Policy.
3. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:

- Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
- Treat or correct Congenital Conditions.

4. Custodial Care.

- Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
- Extended care in treatment or substance use facilities for domiciliary or Custodial Care.

5. Dental treatment, except:

- As described under Dental Treatment in the Policy. This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.

6. Elective Surgery or Elective Treatment.
7. Foot care for the following:

- Flat foot conditions.
- Supportive devices for the foot.
- Subluxations of the foot.
- Fallen arches.
- Weak feet.
- Chronic foot strain.
- Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery). This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.

8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids, except as specifically provided for in the Policy. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to:

- Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
- Cochlear hearing aids.
- A bone-anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

10. Alopecia.
11. Hypnosis.
12. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
13. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
14. Injury sustained while:

- Participating in any intercollegiate or professional sport, contest or competition.
- Traveling to or from such sport, contest or competition as a participant.
- Participating in any practice or conditioning program for such sport, contest or competition.

15. Investigational services.
16. Lipectomy.
17. Participation in a riot or civil disorder. Any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured being engaged in an illegal occupation. Fighting.
18. Prescription Drugs, services or supplies as follows:

- Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
- Immunization agents, except as specifically provided in the Policy.
- Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
- Products used for cosmetic purposes.
- Drugs used to treat or cure baldness. Anabolic steroids used for body building.
- Anorectics - drugs used for the purpose of weight control.
- Fertility agents or sexual enhancement drugs.
- Growth hormones, except when a Medical Necessity.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

19. Reproductive services for the following:

- Procreative counseling.
- Genetic counseling and genetic testing.
- Cryopreservation of reproductive materials and storage of reproductive materials, except as specifically provided in the Policy.
- Premarital examinations.
- Impotence, organic or otherwise.
- Reversal of sterilization procedures.

20. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.

21. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.

22. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.

23. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.

24. Speech therapy, except as specifically provided in the Policy.

25. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

26. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.

27. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

28. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

29. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Filing a claim on Injury or sickness benefits

Claims must be filed within 90 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service Provider does not bill the Insurer directly, and when you have out-of-pocket expenses to submit for reimbursement. In order for claims payment to be made, claims must be submitted in a form acceptable to Insurer.

Medical Claims: Submit your claim via email, following the instructions 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.

1. Claim submission

EDI: 52682 (MBA TPA Payer ID) Fax: +1.915.519.0261 Mail: 6006 North Mesa Street, Suite 108, Coronado Tower, El Paso, TX 79912

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

Settlement of Claims: When claims are presented to the Insurer, the Allowed Amount will be applied towards the Deductible. Once the Deductible has been satisfied, all Allowable Amount will be paid at the percentage listed on the Schedule of Benefits, up to the listed benefit maximum. Note the Allowed Amount is applied towards the Deductible also reduces the applicable benefit maximum by the same amount. If the Plan has an Out-of-Pocket Maximum, once it is met the Plan will begin paying 100% of Allowed Amount for the remainder of insurance coverage, subject to the benefit maximums.

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

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. Confidential medical information will be released only with the Insured Person's written consent.

1. **Subrogation, Reimbursement, and Assignment of Rights**: Benefits paid under the Plan are paid on the condition that we are entitled to pursue subrogation and receive reimbursement for an Injury or Illness for which we have provided benefits when you have accrued a right of action against a third party for causing Injury or Illness for which i) we have paid benefits; and ii) you have received a judgement,

settlement, or other compensation on the basis of that Illness or Injury. We have the right to be reimbursed whether the recovery you receive, or to which you are entitled, is made in a single payment or incrementally over time. Our reimbursement and subrogation rights extend to all amounts available to you or that you have received by judgement, settlement, or other recovery, including but not limited to benefits from policies of insurance issued to you and/or in the name of a covered family member or that otherwise insure to your benefit. We automatically have a lien on any payment you receive or are entitled to receive from any person or entity because of a claim for which we have paid benefits. The lien may be enforced against any party who acquires funds arising out of or attributable to the claim. Our obligation to pay benefits is always secondary to any automobile No-Fault/Personal Injury Protection or medical payments coverage. To the extent that we have paid a benefit for an amount that is payable by any automobile No-Fault/Personal Injury Protection or medical payments coverage, we shall have the right to collect any such amount from the automobile insurer. You and any of your legal representatives shall fully cooperate with our efforts to recover the benefits we have paid. You must notify us within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to the Illness, Injury, or condition for which we have paid benefits. You shall do nothing to prejudice our subrogation or recovery interests or our ability to enforce the terms of these provisions. We have the sole authority and discretion to decide whether to pursue any right of recovery under this provision. We are entitled to and may pursue any and all parties which may be liable to provide compensation to you for the claims at our expense and may bring such action in our name as your subrogee/assignee. You agree to fully assist us in pursuit of our rights and subrogation if we do so by assignment.

General Provisions

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

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

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

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

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

PAYMENT OF CLAIMS: Benefits will be paid to you. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to your estate. Any other accrued indemnities unpaid at the time of your death may, at our option, be paid either to such beneficiary or to such estate. If benefits are payable to your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such indemnity, up to an amount not exceeding $2,000.00, to any one relative by blood or connection by marriage to you who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment. We may pay all or a portion of any indemnities provided for health care services to the provider, unless you direct otherwise, in writing, by the time proofs of Loss are filed or when an ambulance provider is entitled to be paid directly pursuant to applicable law. We cannot require that the services be rendered by a particular provider. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity:

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

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

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

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

RIGHT OF REIMBURSEMENT: If an Insured Person incurs expenses for Sickness or an Injury that occurred due to the negligence of a third party: The Company has the right to reimbursement for all benefits paid by the Company from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person’s parents, if the Insured Person is a minor, or Insured Person’s legal representative as a result of that Sickness or Injury. The Company is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Company for that Sickness or Injury. The Company has the right to reimbursement out of all funds the Insured Person, the Insured Person’s parents, if the Insured Person is a minor, or the Insured Person’s legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury. You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

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

liability may appear. The Company will not seek reimbursement for overpayment of a claim made to a provider after 12 months from the date of the first payment on the claim.

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

Appeal and Grievance Program

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

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

Please contact the Customer Service Department at +1.915.803.4198 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Five Points, 6006 North Mesa Street, Suite 108, El Paso, TX 79912

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for the review Upon receipt of the request for a Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination. Within three working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

- Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
- Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits. Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:
- Any new or additional evidence considered by the Company in connection with the grievance; and
- Any new or additional rationale upon which the decision was based.

The Insured Person or Authorized Representative shall have 10 calendar days to respond to any new or additional evidence or rationale. The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 15 business days after receipt of the required information. The written notice of Final Adverse Determination for the Internal Review shall include:

- The titles and qualifying credentials of the reviewers participating in the Internal Review;
- Information sufficient to identify the claim involved in the grievance, including the following:
- The date of service;
- The name health care provider; and

- The claim amount;
- A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
- For an Internal Review decision that upholds the Company's original Adverse Determination:
- The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
- Reference to the specific Policy provisions upon which the determination is based;
- A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
- If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
- If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
- Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
- A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
- The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
- Notice of the Insured Person's right to contact the Director's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any 1me.

Definitions

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

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

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

Anesthetist: Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Assistant Surgeon: means a Physician who assists the Surgeon who actually performs a surgical procedure.

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

Balance Billing: When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider); a network provider (preferred provider) may not bill you for covered services. Balance billing is prohibited for services protected by the No Surprises Act or other applicable federal or state law, except where a lawful exception applies.

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

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

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

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

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

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

- Not in excess of the Usual and Customary Charge therefore;
- Not in excess of the charges that would have been made in the absence of this insurance;
- Not in excess of the Negotiated Charge; and

- Incurred while this Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

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

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

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

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

1. You would have serious damage to any part or organ of your body.

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

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

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

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

Habilitative Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

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

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

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

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

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

Preventive and wellness services

Hospitalization

Emergency services

Ambulatory services

Prescription drugs

Laboratory services

Mental health and substance use services

Rehabilitative services and devices

Maternity and newborn care

Pediatric services

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

Organ Transplant: The transfer of an organ from one body to another, or from a donor site to another location on the person’s own body, to replace the recipient’s damaged, absent or malfunctioning organ.

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

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

Out-of-pocket Limit: The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges

or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. See a detailed example.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Surgeon: Physician who actually performs surgical procedures.