International
Student
Health
Insurance

ISA Bronze

INTERNATIONAL STUDENT PLAN SUMMARY

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

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

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

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

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

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

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1. GENERAL PROVISIONS

1.1 Parties to the Policy

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

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

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

1.2 Program Governance

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

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

1.3 Entire Policy and Changes

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

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

2. SCHEDULE OF BENEFITS

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

POLICY MAXIMUM BENEFITS	
US PROVIDER NETWORK	Aetna
AREA OF COVERAGE	Worldwide excluding Home Country
MAXIMUM BENEFIT PER COVERED ILLNESS OR INJURY ANNUAL MAXIMUM	$100,000 $250,000
INDIVIDUAL DEDUCTIBLE PER ILLNESS OR INJURY ï In-Network Provider ï Out-of-Network Provider The deductible for In-Network does not accrue towards the Out-of-Network Deductible	 $100 per Insured Person $100 per Insured Person
COPAYMENTS	
Copayments do not apply to the Deductible or the Out-of- Pocket-Maximum	
Student Health Center Copayment Physician/Specialist Office Visit Copayment Hospital Copayment per Admission Urgent Care Center Copayment Emergency Room Copayment (waived if admitted)	$0 per visit $0 per visit $0 per visit $0 per visit $250 per visit
OUT-OF-POCKET-MAXIMUM PER PERIOD OF INSURANCE ï In-Network or Out-of-Network The Deductible, Copayments (including Prescription Medication) does not apply to the Out-of-Pocket Maximum.	Unlimited
PRE-EXISTING CONDITION LIMITATION (12 months Lookback Period)	Student: Pre-existing Conditions are covered a after 6 month Waiting Period. Dependents: Pre-existing Conditions are covered 24 months Waiting Period.
STUDENT HEALTH CENTER	Deductibles and Copayments are waived when services are rendered at the Student Health Center. Services rendered at the Student Health Center are reimbursed at 100%

WHAT THE INSURANCE PLAN COVERS

The following Coinsurance applies for In-Network Providers in the U.S. or for expenses incurred outside the U.S. (if available).

Coinsurance reduces to 80% of UCR when Out-of-Network Providers in the U.S. are used. Coinsurance outside the USA, excluding M1/M2 visa holders is 100% of UCR.

HOSPITALIZATION AND INPATIENT BENEFITS	
ACCOMODATIONS INCLUDING SEMI-PRIVATE ROOM ï Maximum number of days: 30 per Period of Insurance ï Maximum Benefit $1,250 per day	100% Preferred Allowance
INTENSIVE CARE/CARDIAC CARE ï Maximum number of days: 30 days per Period of Insurance ï Maximum Benefit $1,750 per day	100% Preferred Allowance
MENTAL HEALTH ï Maximum number of days: 30 per Period of Insurance	80% Preferred Allowance
INPATIENT CONSULTATION/VISIT BY A PHYSICIAN, OSTEOPATH OR SPECIALIST ï Maximum Benefit: $400 per Admission	100% Preferred Allowance
DIAGNOSTIC TESTING AND HOSPITAL MISCELLANEOUS EXPENSE AND X-RAY AND LABORATORY ï Maximum number of days: 30 per Period of Insurance ï Maximum Benefit $500 per day	100% Preferred Allowance
PRE-ADMISSION TESTING ï Within 3-5 working days prior to admission ï Maximum Benefit: $900 per Admission	
OUTPATIENT BENEFITS	
PRIMARY CARE VISIT ï Office visit Copayment applies ï Maximum Benefit per visit: $50 ï Maximum Number of visits per Period of Insurance: 30 ï Limited to 30 visits per Period of Insurance combined with urgent care and primary care	100% Preferred Allowance

OUTPATIENT BENEFITS (cont)	
PHYSICIAN VISIT OR CONSULTATION BY SPECIALIST ï Office visit Copayment applies ï Urgent Care Copayment applies ï Maximum Benefit per visit: $50 ï Maximum Number of visits per Period of Insurance: 30 ï Limited to 30 visits per Period of Insurance combined with urgent care and primary care	100% Preferred Allowance
DIAGNOSTIC TESTING ï X-Ray and Laboratory Maximum Benefit per Period of Insurance: $500 ï MRI, PET, and CT Scans Maximum Benefit per Period of Insurance: $350 ï Office visit Copayment applies when testing is done outside an office visit	100% Preferred Allowance
THERAPEUTIC SERVICES ï Maximum Number of visits per Injury or Illness: 12 visits ï Maximum Benefit per injury or Illness per visit: $35 ï Office visit Copayment applies	100% Preferred Allowance
MENTAL HEALTH ï Maximum Benefit per Period of Insurance: $3,000 ï Maximum Number of Visits per Period of Insurance: 30 ï Office visit Copayment applies	80% Preferred Allowance
EMERGENCY BENEFITS	
EMERGENCY ROOM AND MEDICAL SERVICES ï Copayment waived, if admitted ï Non-emergency use of the emergency room is Not Covered	80% Preferred Allowance
AMBULANCE SERVICES ï Emergency local ground ambulance ï Maximum Benefit per Period of Insurance: $400	100% Preferred Allowance
EMERGENCY DENTAL ï Limited to accidental Injury of sound natural teeth sustained while covered ï Maximum Benefit per Tooth $500	100% Preferred Allowance

MATERNITY CARE	
NORMAL DELIVERY OR MEDICALLY NECESSARY C-SECTION, PRE-NATAL, POST-NATAL CARE, AND COMPLICATIONS OF PREGNANCY ï Dependent Spouse: Conception must occur at least ten (10) months after Effective Date ï Services must be rendered by an In-Network Physician or In-Network Provider. ï Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider ï This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Insurer, acting through the Plan Administrator in an administrative capacity, will determine eligibility and coverage in accordance with the terms of the Policy. ï Maximum Benefit for normal delivery: $5,000 ï Maximum Benefit for Medically Necessary C-Section delivery: $7,500	100% Preferred Allowance
OTHER BENEFITS (INPATIENT/OUTPATIENT)	
CANCER CARE AND ONCOLOGY ï Inpatient: Maximum Benefit per Period of Insurance: $1,000 ï Outpatient: Maximum Benefit per Period of Insurance: $1,000	80% Preferred Allowance
DURABLE MEDICAL EQUIPMENT ï Reimbursement of rental up to the purchase price ï Maximum Benefit per Period of Insurance: $1,000	100% UCR
ALCOHOL AND SUBSTANCE ABUSE ï Rehabilitative treatment only ï Outpatient Maximum Benefit per visit: $50 ï Maximum Number of days per Period of Insurance: 30 ï Limited to 30 visits per Period of Insurance combined with urgent care and primary care ï Subject to all inpatient maximum benefits	80% Preferred Allowance
PRESCRIPTION MEDICATIONS ï Up to 31-day supply per prescription ï Includes oral contraceptives ï Network pharmacy is Not allowed, Reimbursement only ï Dispensed by Student Health Center	Maximum Benefit per Illness or Injury: $100

NON-MEDICAL EXPENSE BENEFITS

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

MEDICAL EVACUATION	**100% of actual costs**
MEDICAL REPATRIATION	**Actual cost of roundtrip economy airfare**
RETURN OF MORTAL REMAINS	**100% of actual costs**

3. ELIGIBILITY

3.1 Eligible Classes

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

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

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

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

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

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

Who is Eligible:

- **Class 1: J1 valid valid visa holder who is outside their home country and engaged in educational activity and a minimum of 17 years old and a maximum of 64 years old, and is one of the following: 1) an undergraduate student registered for attending classes on a full-time basis or 2) graduate student, or 3) scholar or researcher who is invited by an educational organization, or 4) student involved in education, educational activities, or research related activities.**
- **Class 2: The Spouse of a Class 1 Insured Person**
- **Class 3: The dependents child(ren) of a Class 1 Insured Person**

Who is not Eligible:

- **Students taking distance learning, home study or OPT students**

3.2 Persons Eligible to be an Insured Person

The Insured Person on this Plan is a Non-United States Citizen travelling outside their Home Country and travelling to the United States. Their true, fixed and permanent home and principal establishment is outside of the United States, and they hold a current and valid passport, and for whom proper Premium payment has been made when due.
Insured Persons are those persons described as an Eligible Class. Students who are United States citizens are not eligible for coverage.

3.3 Eligible Dependents

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

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

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

3.4 Effective and Termination Date of Coverage

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

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

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

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

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

3.5 Addition of a Newborn Baby or Legally Adopted Child

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

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

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

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

Born When an Insured Person is Not Covered by the Maternity Benefit:

Newborn babies, that are born, and the Insured Person is not covered by the maternity benefit under this Plan, may be covered subject to the following:

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

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

3.6 Adoption of a Legally Adopted Child After the Date of Birth

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

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

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

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

3.7 Extended Coverage

The Extended Coverage benefit is available to newly enrolled students who arrive in the United States prior to the beginning of the first term of study in the United States, or Insured Persons who have completed their final term of study in the United States and are preparing to return to the Home Country. The Extended Coverage benefit provides up to 60 days of additional coverage.
Extended Coverage does not apply to Insured Persons who are continuing their studies or returning to studies in the United States whether at the same or different institutions.

Newly Enrolled and Arriving Students

To be eligible for the Extended Coverage Benefit and before any benefits will be paid:

1. **A newly enrolled and arriving student must have enrolled in full-time studies at the higher education institution, and**
2. **All Premiums must be paid.**

Coverage under the Extended Coverage Benefit will become effective on the later of:

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

Students Concluding their Studies

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

1. **The Insurer must receive the request for Extended Coverage prior to the termination of the Insured Person's coverage, and**
2. **All Premiums must be paid.**

Coverage under the Extended Coverage Benefit will terminate on the earlier of:

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

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

Extended Coverage for Short-Term Programs

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

4. PREMIUM, CANCELLATION AND POLICY PROVISIONS

4.1 Premium Payment

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

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

4.2 Cancellation

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

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

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

4.3 Period of Insurance

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

4.4 Duration of Coverage

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

4.5 Compliance with the Policy Terms

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

4.6 Fraudulent/Unfounded Claims

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

4.7 Waiver of Terms or Conditions

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

4.8 Denial of Liability

Neither the Insurer, Plan Administrator nor Plan Marketer shall be liable for the quality of medical care rendered by any provider, nor for delays, acts, omissions, negligence, or services provided by third-party medical providers, transportation vendors, or healthcare facilities. This insurance coverage does not

give the Insured Person any claim, right or cause of action against the Insurer, Plan Administrator or Plan Marketer based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

4.9 Extension of Benefits

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

4.10 Pre-Existing Condition Limitation

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

4.11 Preferred Provider Network

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

United States only:

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

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

5. PRE-AUTHORIZATION REQUIREMENTS AND PROCEDURES

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

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

The following services require Pre-Authorization:

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

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

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

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

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

6. MEDICAL COVERAGE

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

EXCESS PROVISION

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

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

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

- **Incurred as a result of illness or accidental injury under the care of a Physician**
- **Ordered or recommended by a licensed Health Care Provider and under the scope of the Physician's licensing.**
- **Medically necessary, and**
- **Delivered in an appropriate medical setting.**

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

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

7. EMERGENCY SERVICES

7.1 Serious Accident Hospitalization

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

7.2 Ground Ambulance Services

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

7.3 Air Ambulance and Medical Evacuation

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

- **Emergency evacuation is only covered if related to a covered condition under the Policy, for which treatment cannot be provided locally, and transportation by any other method is not medically advisable.**
- **Redbridge retains the right to decide the facility to which the Insured shall be transported. Approved medical evacuations will be to the nearest medical facility capable of providing the necessary medical treatment or the student's Home Country. If the Insured Person chooses not to be treated at the facility and location arranged by the Insurer, then transportation expenses shall be the responsibility of the Insured. Failure to arrange transportation as indicated will result in non-payment of transportation costs.**
- **You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of 5 or more consecutive days immediately prior to medical evacuation;**
- **Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved, the medical evacuation;**
- **We must approve the expenses incurred prior to the medical evacuation occurring, if applicable;**
- **No benefits are payable for expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;**
- **Evacuation to Your Home Country terminates any further insurance coverage under this Certificate for You; and**
- **Transportation must be by the most direct and economical route.**
- **The Insured agrees to hold the Insurer, including all of its subsidiaries, affiliates and parents, harmless from any negligence resulting from such transportation services, as well as for delays or restrictions caused by mechanical problems or governmental restrictions; errors, omissions, or negligence by the pilot, driver, or crew; or operational, weather, or any other adverse conditions.**

7.4 Emergency Room and Medical Services

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

7.5 Emergency Dental Care

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

7.6 Treatment in Urgent Care Centers

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

7.7 Repatriation

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

8. INPATIENT SERVICES

8.1 Room and Board Expense

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

Not Covered Under This Benefits

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

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

8.2 Intensive Care.

See Schedule of Benefits.

8.3 Hospital Miscellaneous Expenses.

When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Benefits will be paid for services and supplies such as:

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

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

8.4 Surgery
Physician's fees for Inpatient surgery.

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

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

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

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

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

9. MENTAL HEALTH AND SUBSTANCE DISORDER

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

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

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

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

9.2 Substance Abuse Benefits

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

10. OUTPATIENT BENEFITS

10.1 Surgery

Physician's fees for Inpatient surgery.

10.2 Physical Therapy

It must be serviced by licensed therapist.

10.3 Dental Treatment

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

Office Visits

1. Telehealth or Telemedicine

for health care delivery, diagnosis, consultation, or Treatment provided to You by a Physician or a contracted provider subject to the plan cost share shown on the Schedule of Benefits.

2. Physician's office visit

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

3. Allergy Test and Treatment

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

4. Chiropractic Care

Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

5. Tuberculosis screening(TB), Titers, QuantiFERON B tests

when required by the School for high risk Insured Persons.(other than covered under Preventive Care Services)

Diagnostic Lab, Testing and Imaging Service

1. Lap Test, X-Ray and other Test

diagnostic X-ray services when prescribed by a Physician and laboratory procedures when prescribed by a Physician.

2. Advanced Imaging Services(CT Scan, MRI and/or PET Scan)
diagnostic services when prescribed by a Physician.
Inpatient: services can be allowed in hospital.
Outpatient: services are allowed not in hospital but in Free-standing facilities

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

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

11. MATERNITY AND NEWBORN CARE

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

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

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

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

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

11.3 Complication of Pregnancy
Arise within the ten (10) month Waiting Period are not covered.
Complications of Pregnancy covers the mother only and may be denied if the mother does not obtain the appropriate and recommended pre-natal care as directed by her medical provider.

This benefit is subject to Pre-Authorization and notification within 30 days of pregnancy confirmation. The Plan Administrator will determine coverage upon receipt of the Pre-Authorization request.

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

11.4 Abortion
for the expense of an elective, non-therapeutic, abortion.
Not Covered Under this Benefit
Elective C-sections are not covered.

12. PRESCRIPTION DRUGS

Medications filled in an outpatient pharmacy for which a Physician's written prescription is required. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-authorization. These prescription requirements help Your prescriber and pharmacists check that Your outpatient Prescription Drug is clinically appropriate using evidence-based criteria.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are

less expensive than brands.
Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

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

12.1 Off-Label Drug Treatment

When Prescription Drugs are provided as a benefit under this Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), if all the following conditions have been met:

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

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

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

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

12.2 Dispense as Witten

If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug.

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

12.3 Spense limit

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

in case of over 30 days up to 90 days, additional copay will be charged.

12.4 Tier changes

The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Prescription Drug that becomes available as a Generic Prescription Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status by emailing Redbridge customer service at amgroup@redbridge.cc.

12.5 Compounded Prescription Drugs

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

13. OTHER SERVICES

13.1 Durable Medical Equipment

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

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

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

Not Covered Under this Benefit

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

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

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

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

Medical evacuation and Repatriation

1. Medical evacuation

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

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

2. Repatriation

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

14. CLAIMS PROCEDURES

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

14.1 Settlement of Claims

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

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

14.2 Fraudulent Claims

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

Claims must be filed within 180 days of treatment to be eligible for reimbursement of covered expenses. Claim forms should be submitted only when the medical service Provider does not bill the Insurer directly, and when you have out-of- pocket expenses to submit for reimbursement. For claims payment to be made, claims must be submitted in a form acceptable to Insurer.

14.3 Medical Claims

Submit your claim via email. Follow up guidelines on the claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.

Claims may be submitted to the Insurer directly by the Provider or Facility. The Insurer will process the claim according to the Schedule of Benefits and Plan terms, and remit payment to the Health Care Provider. Ineligible charges or those in excess of the Allowable Charges will be the responsibility of the Insured Person.

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

14.4 Claim submission / Customer Service

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

14.5 Reimbursement

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

14.6 Status of Claims

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

14.7 Releasing Necessary Information

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

14.8 Coordination of Benefits

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

15. SUBROGATION, REIMBURSMENT AND ASSIGNMENT OF RIGHTS

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

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

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

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

16. COMPLAINTS PROCEDURE

At times, you may have a concern You would like to tell Us about or disagree with a decision made regarding Your coverage. You can make a compliant or file an appeal to get help for Your situation. The following procedures must be followed for a complaint to be reviewed.
The most important factors in getting Your complaint dealt with as quickly and efficiently as possible are:

- **Be sure You are talking to the right person; and**
- **That You are providing the necessary information.**

When You Contact Us

Please provide the following information:

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

Making a Complaint

If Your complaint relates to:

- **The sale of the policy that you purchased or any information you were given during the sales process, contact the broker or other intermediary first.**

- **We always aim to resolve Your complaint and provide a final response within four weeks, but if it looks like it will take us longer than this, we will let you know the reasons for the delay and regularly keep you up-to-date with our progress.**

17. NOTICE OF PRIVACY PRACTICES

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

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

How We May Use or Disclose Your Personal Information

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

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

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

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

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

Or

Info@spectrumbenefitsinc.com

18. GENERAL EXCLUSIONS

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

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

1. Abortion: **Any voluntarily induced termination of pregnancy and complications thereof, except if the mother's life is in danger**
2. Alcohol and Substance Abuse: **1) Treatment of any Illness or Injury caused by, contributed to, or resulting from voluntary use of alcohol, illegal substance abuse, drug, poison, gas or fumes, or any medication that is not taken in the dosage or for the purpose prescribed. 2) Medical expenses related to diagnosis, detoxification, counseling or other rehabilitative services unless the benefit is provided for on the Schedule of Benefits.**
3. AIDS/HIV: **Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex Syndrome (ARC), HIV positive, all secondary diseases, and all sexually transmitted diseases.**
4. Breast Reduction: **All services and treatments.**
5. Charges Reimbursable by Another Entity: **Services, supplies, or treatment that are provided by or payment is available from: a) Workers' Compensation law, occupational disease law or similar law concerning job related conditions of any country; or; b) Another insurance company or government; or c) A government entity due to an epidemic or public emergency; d) Services provided normally without charge by the Health Services Center of the institution attended by the Insured Person, or services covered or provided by a student health fee.**
6. Cosmetic and Elective Surgery for Non-Medical Reasons: **Treatments, procedures or medications which are primarily for enhancement, improvement, or altering one's appearance, unless required due to a non-occupational Injury occurring while insured under this Plan. Medical complications arising from such treatments or procedures are also not covered.**
7. Dental Care: **a) Except for Accidental injury to sound, natural teeth b) unless pediatric dental is shown on the Schedule of Benefits.**
8. Experimental or Off-Label Services: **Services, supplies or treatments, including medications, which are deemed to be Experimental or Investigational or that is not medically recognized for a specific diagnosis.**
9. Fertility/Infertility Treatments and Birth Control: **Any services, procedure or treatment including medications used to: a) Treat infertility including In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and any variations of these procedures, and any costs associated with the preparation or storage of sperm for artificial insemination. b) Vasectomies and sterilization, and any expenses for male or female reversal of sterilization.**
10. Gender Identity Disorder: **Medical, surgical, and mental health expenses including prescription medications, and the medical complications arising from any treatments or procedures related to gender identity or gender dysphoria.**

11. Gender Identity Disorder: **Medical, surgical, and mental health expenses including prescription medications, and the medical complications arising from any treatments or procedures related to gender identity or gender dysphoria.**
12. Genetic Screening: **Counseling, screening, testing, or treatment in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.**
13. Hearing Care: **Hearing exams, hearing aids or devices, unless due to an Injury/Illness covered under the Plan. Surgical implantation of, or removal of bone anchored hearing devices and cochlear implants.**
14. Home Country: **a) All medical charges incurred in the Insured Person's Home Country, in excess of the amount shown on the Schedule of Benefits.**
15. Illegal Activities: **Injuries or Illnesses resulting or arising from or occurring during the commission of an assault or felony.**
16. Immunizations for Travel: **Vaccines and preventive medications recommended or required for travel to specific countries.**
17. Motor Vehicle: **Medical expenses; 1) Resulting from a motor vehicle Accident unless the benefit is provided for on the Schedule of Benefits; 2) If the operator of a motor vehicle is the Insured Person and does not possess a valid motor vehicle operator's license in the jurisdiction in which the motor vehicle Accident occurred, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor; 3) The operating of any type of vehicle or conveyance while under the influence of alcohol or any illegal substance, drug, poison, gas, or fumes including prescribed drugs for which the Insured was provided a written warning against operating a vehicle or conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the jurisdiction in which the Covered Loss occurred.**
18. Nasal Surgery: **Deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus surgery except for treatment of a covered Injury.**
19. Non-Medical Care: **Services related to Custodial Care, respite care, home-like care, assistance with Activities of Daily Living (ADL), or Milieu Therapy. Any Admission to a nursing home, home for the aged, long term care facility, sanitarium, spa, hydro clinic, or similar facilities. Any Admission arranged wholly or partly for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.**
20. Organ Transplant: **Organ transplant and related procedures and expenses.**
21. Podiatric Care: **Routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails or other such services not resulting from an Illness or Injury. Orthopedic shoes or other supportive devices such as arch supports, orthotic devices, or any other preventative services or supplies to treat the diagnosis of weak, strained, or flat feet or fallen arches.**
22. Pre-Existing Conditions: **a) Treatment and expenses for routine care and maintenance related to Pre-Existing Conditions, unless coverage is provided for and shown on the Schedule of Benefits, b) Treatment and expenses incurred during a Waiting Period if shown on the Schedule of Benefits.**
23. Prescription Medications: **Prescription Medications, services or supplies as follows: a) Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in this Plan, b) Immunization agents, except as specially provided, biological sera, blood or blood products administered on an Outpatient basis, c) Refills in excess of the number specified or dispensed after one year of the date of the prescription, d) Growth hormones, e) Medications used to treat or cure baldness or thinning hair.**
24. Preventive Care and Immunizations: **Immunizations for travel or medical, screening tests, and other diagnostic procedures in the absence of an Illness, unless as part of an annual physical exam or standard annual immunization.**
25. Services for Administrative Purposes: **health check-ups, inoculations, immunizations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.), other than as provided for under the Wellness and Preventive Services benefit.**

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

NON-MEDICAL EXPENSE BENEFITS EXCLUSIONS AND LIMITATIONS

1. **Travel costs that were neither arranged or approved in advance by the Insurer or authorized vendor or affiliate.**
2. **Taking part in military or police operations.**
3. **Insured Person's failure to properly procure or maintain visa, permits, or other documents.**
4. **The actual or threatened use or release of any nuclear, chemical, or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of the contributory cause.**

5. **Any evacuation or Repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.**
6. **Medical evacuation from a marine vessel, ship, or watercraft of any kind.**
7. **Medical evacuation directly or indirectly related to a natural disaster.**
8. **Subsequent medical evacuations for the same or related Illness, Injury, or emergency medical evacuation event regardless of location.**

ACCIDENTAL DEATH AND DISMEMBERMENT EXCLUSIONS AND LIMITATIONS

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

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

19. DEFINITIONS

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

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

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

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

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

Balance Billing: **When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.**