International Student Health Benefits

California State University Chico

WellAway
Keeping You Well, While You're Away.®

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Health Care Coverage and Benefits

Scope of Coverage

This Policy is designed to provide coverage while you are studying abroad and temporarily residing in the United States. The benefits stated in this Policy are only applicable when the Insured Person is outside his or her Home Country. ***This Policy does not cover United States citizens residing in the United States. As such, this Policy is not subject to, and is not administered as a Patient Protection and Affordable Care Act insurance policy and is not subject to guaranteed issuance or renewal.***

These terms and conditions (the "Policy") describe each party's rights and obligations, what the plan covers and how benefits are paid for that coverage. It is important that you read and understand the Policy to make sure you are aware of any waiting periods, limitations and exclusions. When reading through the Policy, capitalized words are defined terms whose definition appears in the Definitions section of this Policy.

Please note that benefits are subject to Deductible, Coinsurance, Copayment and Maximum Benefit amounts (as applicable). We agree to provide coverage, up to the limits stated in this Policy, for Covered Expenses of Covered Services in accordance with the conditions, limitations and exclusions stated in this Policy. The Policyholder's receipt of the Policy shall constitute delivery to each Insured Person. All benefit amounts are stated in United States dollars. If you have any questions, please contact a ConciergeCare Counselor.

Important Information

- ***Where do I go for medical care?***

    - **Student Health Center:** We always recommend that you visit your Student Health Center for all your medical services, treatments, and procedures, when available. There is no Copayment when you use your Student Health Center.

    - **Non-Emergency/Non-Urgent Care:** If the Student Health Center does not provide the required care and you have a non-emergency situation, please contact a ConciergeCare counselor at the telephone number on the back of your ID card to guide you to the appropriate In-Network Provider (i.e., local doctor, walk-in clinic, or urgent care facility) in your area and assist you in scheduling an appointment. Utilizing a hospital emergency room for non-emergency care will result in additional expenses and out of pocket costs to you. You will be charged a Copayment when you use an emergency room (waived if admitted). ***If you use an emergency room in the Hospital for a non-emergency service, your Coinsurance will be reduced to 50%.***

    - **Emergency Care:** In case of a serious medical emergency, contact emergency services at 911. After the proper authorities have been contacted, contact ConciergeCare so we can lead you in the right direction and help you through any hardship you may have.

  If you are unsure whether you should visit an urgent care center/convenience care clinic or an emergency room, contact a ConciergeCare counselor who may guide you to the appropriate Provider. You may reach a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com. In the event of an emergency, however, you should always contact emergency services wherever you are located.

- ***Pre-Existing Condition Limitation and Waiting Periods:*** Your Policy contains a Waiting Period for Pre-Existing Conditions and any medical Services or Prescription Medications/Drugs for, related to, or resulting from complications of a Pre-Existing Condition. However, during the Waiting Period we will cover Services related to a Pre-Existing Condition(s) up to a Maximum Benefit amount of $2,500.

- ***Certain procedures and medical services covered by your Policy require Pre-Authorization*.** If Services have not been coordinated or approved by the Plan Administrator, if required under the Policy, it will result in a 30% penalty (*if a covered Service*) on the entire episode of care (*all Services including, but not limited to, Hospitalization, Procedures, Treatments, and Physician fees)* and does not apply to the Out-of-Pocket Maximum. If the Service would not have been approved by the Pre-Authorization process under this Policy, all related claims will be denied. ***Please refer to What Your Plan Covers for all Services and Procedures that require Pre-Authorization (which are indicated by an asterisk).***

- ***Prescription Medication:*** You must present your ID card to the pharmacy, along with your Copayment, when the prescription is filled. If you do not use an In-Network pharmacy, you will be responsible for paying the full cost for the Prescription Drug. If you do not present your ID card, you may need to pay for the Prescription Drug and then submit a Reimbursement form for the Prescription Drug along with the paid receipt and Prescription Drug receipt in order to be considered for Reimbursement. For inquiries regarding your Medication Program, Prescription Drug Benefits or to obtain information regarding participating pharmacies, please contact your ConciergeCare Counselor or visit the PBM website at www.ehimrx.com.

- ***Out-of-Network benefits are subject to Usual, Reasonable and Customary Charges*.** We do not cover any amounts that are not within Usual, Reasonable and Customary Charges. We recommend that you notify us of any planned inpatient procedure, outpatient procedure, diagnostic services or laboratory tests to ensure full reimbursement of the medical services provided. Your Provider should advise you of the costs of the recommended Treatment or Procedure. If the costs of the Treatment or Procedure are likely to exceed Usual, Reasonable and Customary Charges, you should request a written estimate and contact WellAway before any Treatment or Procedure takes place.

What Your Plan Covers

This section is a summary and full description of the benefits covered under this Policy. Please read the benefit descriptions for complete details of your coverage. All covered benefits are subject to: (i) your Cost Share amounts and any benefit maximums listed on your Summary of Benefits; (ii) the Allowable Charges (In-Network) or Usual, Reasonable and Customary Charges (Out-of-Network), as applicable; and (iii) any limitations and Exclusions.

Area of Coverage	Worldwide
Maximum Limit	$300,000
Pre-Existing Condition limitation *(Look-back Period is 12 months)*	Student: 6-month Waiting Period - **Maximum Benefit $2,500 coverage during Waiting Period** Dependent(s): 24-month Waiting Period - **No coverage during Waiting Period**
Pre-Authorization	Services and Procedures that require Pre-Authorization are indicated by an asterisk

Deductible	**In-Network** In-Network Physician and In-Network Facility	**Out-of-Network** (subject to Usual, Reasonable and Customary charges (URC))
In-Network and Out-of-Network Deductibles accrue separately	$0	$0

Copayments		
Student Health Center	$0	$0
Office Visit	$20	$20
Urgent Care	$20	$20
Hospital Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)
Hospitalization or Surgery	$50	$50

Coinsurance	
In-Network Physician and Facility	100% of Allowable Charges
Out-of-Network Providers	80% of URC

Out-of-Pocket Maximum		
Copayments (including Prescription Medication Copayments) do not apply towards Out-of-Pocket Maximum	$3,000	$5,000

Outpatient Medication Program	
EHIM In-Network Pharmacy	Tier 1 $10 Copayment per prescription Tier 2 $20 Copayment per prescription Tier 3 $40 Copayment per prescription
Out-of-Network	Not covered

Summary of Benefits	In-Network In-Network Physician and In-Network Facility	Out-of-Network (subject to Usual, Reasonable and Customary charges (URC))
Wellness and Preventive Services		
Adult Wellness Visit and Preventive Services **Well Childcare Visits**	100% of Allowable Charges 100% of URC at Student Health Center Maximum benefit $500	Not covered
Services That Require Hospitalization		
Pre-admission Testing	100% of Allowable Charges	80% of URC
Hospitalization*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/ Trauma/Pediatric Intensive Care*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Inpatient Treatment for Mental Illness*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Emergency Medical Services in an Emergency Room *If you use an emergency room in the Hospital for a non-emergency service, Coinsurance will be reduced to 50%.*	100% of Allowable Charges $100 Copayment (waived if admitted)	80% of URC $100 Copayment (waived if admitted)
Emergency Treatment of a Pre-Existing Condition	100% of Allowable Charges Maximum benefit $2,500	80% of URC Maximum benefit $2,500
Voluntary HIV Screening (*during an emergency room visit)*	100% of Allowable Charges	80% of URC
Inpatient Physician, Osteopath and Specialist Services	100% of Allowable Charges	80% of URC
Inpatient Ancillary Hospital Services	100% of Allowable Charges	80% of URC
Inpatient Advanced Diagnostic Services	100% of Allowable Charges	80% of URC
Inpatient Routine X-Ray and Lab Tests	100% of Allowable Charges	80% of URC
Inpatient Oncology Treatment*	100% of Allowable Charges	80% of URC
Inpatient Reconstructive Surgery*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Inpatient Rehabilitation*	100% of Allowable Charges 45-day limit per Policy Period	80% of URC 45-day limit per Policy Period
Inpatient Private Duty Nursing Care*	100% of Allowable Charges	80% of URC
Inpatient Surgical Procedures*	100% of Allowable Charges	80% of URC
Emergency Ground Ambulance	100% of Allowable Charges	80% of URC
Outpatient Care		
It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.		
Urgent Care Clinic / Facility	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Outpatient Ambulatory Surgical Facility & Surgical Care*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Basic Diagnostic Services *Office visit Copayment applies when testing is done outside an office visit*	100% of Allowable Charges	80% of URC

* Pre-authorization required

Summary of Benefits	In-Network In-Network Physician and In-Network Facility	Out-of-Network (subject to Usual, Reasonable and Customary charges (URC))
Outpatient Care		
It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.		
Advanced Diagnostic and Imaging Services *Office visit Copayment applies when testing is done outside an office visit*	100% of Allowable Charges	80% of URC
Outpatient Therapeutic Services	100% of Allowable Charges $20 Copayment and Maximum 20 visits per Injury or Illness	80% of URC $20 Copayment and Maximum 20 visits per Injury or Illness
Outpatient Oncology Treatment*	100% of Allowable Charges	80% of URC
Outpatient Reconstructive Surgery*	100% of Allowable Charges $50 Copayment	80% of URC $50 Copayment
Emergency Dental Treatment	100% of Allowable Charges Maximum benefit $500 per Policy Period and $250 per tooth	80% of URC Maximum benefit $500 per Policy Period and $250 per tooth
Physician Services		
Primary Care Visit	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Specialist Visit	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Outpatient Mental Illness	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Other Services		
Allergy Testing and Treatment	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Alcohol and Substance Abuse* *(rehabilitative only)*	100% of Allowable Charges $20 Copayment	80% of URC $20 Copayment
Self-Inflicted Injury or Illness *(no maximum benefit if related to alcohol and substance abuse)*	100% of Allowable Charges Maximum benefit $10,000	80% of URC Maximum benefit $10,000
Home Health Care*	100% of Allowable Charges	80% of URC
Diabetic Medical Supplies *(includes insulin pumps and associated supplies)*	100% of URC	80% of URC
Durable Medical Equipment *(reimbursement of rental up to the purchase price)*	100% of URC	80% of URC
Maternity Care and Birth Benefits		
Maternity Care* *(subject to notification within 30 days of pregnancy confirmation)*	100% of Allowable Charges	80% of URC
Non-healthy Newborn Infant Care Services*	100% of Allowable Charges	80% of URC
Habilitative Services for Congenital/Birth Defects*	100% of Allowable Charges	80% of URC
Elective Medical Abortion*	100% of Allowable Charges	80% of URC
Worldwide Coverage *(outside the United States)*	100% of URC Home Country coverage subject to maximum 30 days and $1,000 per Policy Period	

We highly recommend that you use an In-Network Physician and In-Network Facility because you can anticipate your health care costs. Contact a ConciergeCare counselor at the number on the back of your ID Card to assist you in locating an In-Network Physician and In-Network Facility. In-Network benefits will be paid at the In-Network Coinsurance percentage, subject to Usual, Reasonable and Customary Charges and Maximum Benefit amounts.

* Pre-authorization required

Wellness and Preventive Services

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

Adult Wellness Visit and Preventive Services

- Your Physician will measure your height, weight, take your blood pressure and take other routine measurements; review your medical and family history; assess your risk factors for preventable diseases; check vital signs; perform head and neck exam, lung exam, abdominal exam and look for signs of cognitive impairment; test your reflexes; review your health risk assessment questionnaire; update your list of providers and prescriptions; and set up a screening schedule for appropriate preventive services
- Immunizations and vaccinations: Diphtheria, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (flu shot), Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox), COVID-19 ***(immunizations and vaccinations must be obtained at the Student Health Center or at an EHIM In-Network pharmacy)***
- Preventive screenings **(1 per year)**
  - Papanicolaou (PAP) screening
  - Mammogram (eligible age: 40 years and over)
  - PSA screening test (eligible age: 50 years and over)

Well childcare visits

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

Services That Require Hospitalization

Pre-admission testing

Must be performed within seven (7) business days in advance of an Inpatient hospitalization or Surgery in a Physician's office or at a participating lab under the order of the admitting Physician

Hospitalization*

Hospital Room and Board, special diets and general nursing care. All charges in excess of the allowable semi-private maximum daily rate will be the responsibility of the Insured Person. All Treatment must be Medically Necessary and Pre-Authorized by the Plan Administrator. The facility must be an accredited Hospital where the Insured Person is being treated. The Hospital must be operated under constant medical management, have suitable diagnostic and therapeutic facilities and keep complete medical records.

Not Covered: This Policy does not cover deluxe rooms, executive rooms and suites or any other patient convenience items. Personal comfort and convenience items including, but not limited to, all non-medical consumables and catering, television, movies, or media related expenses, housekeeping Services, guest meals and accommodations, special diets, telephone charges, take home Supplies or Services for the purpose of receiving non-acute, long term custodial care, respite care, chronic maintenance care or assistance with Activities of Daily Living.

Intensive care unit/telemetry/surgical intensive care/ medical intensive care/trauma/pediatric intensive care*

An intensive care unit may be utilized, if it is the most appropriate place for the Insured Person to be treated, the care provided is an essential part of the Insured Person's Treatment, and the care provided is routinely required by patients suffering from the same type of Illness or Injury or receiving the same type of Treatment. The Hospital is responsible for providing updated medical records with the progress of the Insured Person and any further Treatment plans in order to confirm the Eligibility of coverage based on Medical Necessity.

Not Covered: Treatments not Medically Necessary, Inpatient stay in the Hospital for an inappropriate period of time and when the Treatment received is not provided by a Physician or Specialist.

Services That Require Hospitalization

Inpatient treatment for mental illness*

Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician. We will only cover the costs of Inpatient psychotherapy if the Treatment is provided by a Psychiatric Physician, psychotherapist or other specialist with appropriate qualifications in the field of psychiatry, psychotherapy or psychoanalysis (subject to the Inpatient Physician/Specialist Visits benefit). All Treatment must be Pre-Authorized by the Plan Administrator.

Not covered: (i) Services for education or special education or job training whether or not given in a Facility that also provides medical or Psychiatric Treatment, Treatment for learning difficulties, hyperactivity, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, or any developmental and behavioral problems, any care for autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation which extends beyond traditional medical management or for environmental or social change; (ii) Inpatient (overnight) mental health Services received in a residential treatment facility; (iii) primal therapy, bioenergetic therapy or psychodrama; or (iv) Services for, or in connection with marriage, family, child, career, social adjustment or behavioral, pastoral, bereavement or financial counseling.

Emergency medical services in an emergency room

When your symptoms are severe and your health is in jeopardy, causing loss of life, limb or death, Medical Emergency Services are covered when such Services meet the definition of Medical Emergency Services. Our medical advisors will evaluate the medical records and a determination will be made based on Medical Necessity if care should have been sought at a Convenience Care/Urgent Care Clinic in lieu of an emergency room in the Hospital.

Not covered: If you use an emergency room in the Hospital for a non-emergency service, your Coinsurance will be reduced to 50%.

Emergency Treatment of a Pre-Existing Condition

Benefits for routine care and maintenance of a Pre-Existing Condition are not covered. In the event of a Medical Emergency resulting from a Pre-Existing Condition, the Policy will cover costs for the immediate relief and stabilization of an acute symptom of a Pre-Existing Condition up to the Maximum Benefit amount of $2,500.

Not covered: continued care or Hospitalization beyond the treatment of the acute symptom.

Voluntary HIV Screening

Benefits will be paid for the cost of a voluntary HIV screening test for the Insured Person who is receiving Medical Emergency Services in an emergency room, other than HIV screening, whether or not the HIV screening test is necessary for the Treatment of the Medical Emergency Services. Benefit includes one HIV screening test, the cost of administering such test, all laboratory expenses to analyze the test, the cost of communicating to the Insured Person the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive Services.

Inpatient Physician, Osteopath and Specialist Services

Inpatient Physician visits are limited to one (1) per day per specialty and must be Medically Necessary. Visits in excess of this amount will become the Insured Person's responsibility. Visits that are part of normal preoperative and postoperative care are covered under the Inpatient Surgeon Fees category set forth below and the Insured Person will not pay separate charges for such care.

Inpatient Ancillary Hospital Services

If Medically Necessary for the Diagnosis and Treatment of the Illness or Injury for which an Insured Person is hospitalized, the following Services are covered:

- Use of the operating room and recovery room
- All medicines administered while you are an Inpatient
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and Services
- Medical and Surgical Supplies and Dressings
- Respiratory therapy rendered by a Physician or registered respiratory therapist

Inpatient advanced diagnostic services

(e.g., MRI, CT scans, nuclear imaging) All diagnostic Treatment must be Medically Necessary for the Treatment of an Injury or Illness.

Services That Require Hospitalization

Inpatient Routine x-ray and lab tests

Tests commonly performed while Inpatient. Basic diagnostic Treatment must be Medically Necessary for the Treatment or Diagnosis of an Injury or Illness.

Inpatient Oncology treatment*

Includes diagnostic tests, oncologist fees, Surgery, radiation therapy and chemotherapy alone or in combination from the point of Diagnosis. Radiation therapy must be rendered by a radiologist for proven malignancy or neoplastic diseases. Chemotherapy must be rendered by a Physician or Nurse under the direction of a Physician. Prescription Medication for Cancer treatments which have approved efficacy and market distribution will be covered subject to the Maximum Benefit amounts for Oncology Treatment. All Treatment must be Pre-Authorized by the Plan Administrator.

Inpatient Reconstructive surgery*

As a result of a medical condition, Illness, Injury or Accident which first occurred while the Insured Person is covered under this Policy e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability. Reconstructive Surgery must be performed within twelve (12) months from the date of the Illness, Injury or Accident. This benefit is subject to Pre-Authorization in writing by the Plan Administrator.

Not Covered: (i) Reconstructive surgery as a result of an Accident which did not first occur while covered under this Policy or not performed within the timeframe as specified under the terms and conditions of this Policy; or (ii) Dental reconstructive surgery, microsurgery, replantation and plastic surgery.

Inpatient Rehabilitation*

Benefits are available for an Inpatient Confinement provided in an approved Extended Care Facility following an Admission to a Hospital as a result of an Illness or Injury. Includes physical, pulmonary and cardiac rehab (when medically supervised after heart attack, heart failure or invasive heart procedures) which is initiated post-surgery and continued as an outpatient. Care provided must be at an accredited Rehabilitation unit of a Hospital, at a skilled level. Coverage for Confinement is subject to Pre-Authorization. Covered Services include:

- Skilled nursing and related Services on an Inpatient basis for Insured Persons who require medical or nursing care for an Illness. An Inpatient Confinement includes all approved Extended Care Facility Admissions not separated by at least 180 days.
- Rehabilitation for Insured Persons who require such care because of an Illness or Injury.

Treatment must be under the direct supervision and control of a Specialist and coverage is provided for:

- Use of special Treatment rooms;
- Physical therapy fees;
- Speech therapy fees; and
- Occupational therapy fees.

Care must begin immediately following your Hospital stay of no less than three (3) days. Insurer has the right to review a Confinement, as it deems necessary, to determine if the stay is Medically Necessary. Insurer will reimburse one (1) Physician visit per day per specialty while the Insured Person is a patient in a Hospital or approved Extended Care Facility. Visits that are part of normal preoperative and postoperative care are covered under the Surgical fee and Insurer will not pay separate charges for such care.

Not Covered: Any costs Incurred for accommodation in conjunction with the need for long-term care and custody including, but not limited to: rest cures, Custodial Care, intermediate or home-like care, assistance with Activities of Daily Living, speech therapy for speech impediments or developmental delays, milieu therapy for rest and/ or observation, whether or not prescribed by a Physician, any Admission to a nursing home, home for the aged, long term care or Rehabilitation Facility, sanatorium, spa, hydro clinic or similar facilities that do not meet the Policy definition of a Hospital, any Admission, arranged wholly or in-part for domestic reasons, where the Hospital effectively becomes or could be treated as the Insured Person's home or permanent abode.

Services That Require Hospitalization

Inpatient Private Duty Nursing Care*

Inpatient private duty nursing Services are covered if all of the following criteria are met:

- The nurse is a registered nurse and providing only private duty nursing Services;
- Received when an Insured Person is confined as an Inpatient;
- Ordered by a licensed Physician; and
- Medically Necessary and must be Pre-Authorized by the Plan Administrator.

Note: General nursing care provided by the Hospital is not covered under this benefit.

Inpatient Surgical Procedures*

Surgeries related to an Injury or Illness and fees which are charged by the main surgeon that performed the surgical procedure that are Medically Necessary. Follow-up visits for the first sixty (60) days following Surgery are part of the global fee charged by the Physician and are not reimbursable as a separate fee. However, certain expenses will not be covered due to the following:

1. When multiple Surgeries are performed in addition to the primary Surgery, on the same or different areas of the body, during the same operative session, our payment will be based on 50% of the Allowable Charges for any secondary Surgery performed and is subject to the Cost Share amount (if any). This limitation applies to all bilateral Procedures and all Surgery Procedures performed on the same date of service.
2. Payment for incidental Surgery Procedures is limited to the Allowable Charges for the primary Procedure, and there is no additional payment for any incidental Surgical Procedure. An "incidental Surgical Procedure" includes Surgery where one, or more than one, Surgery is performed through the same incision or operative approach as the primary Surgery, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the Surgical session.
3. Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. The assistant surgeon must be authorized by us prior to the Surgery taking place.
4. Benefits are provided for the Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered surgical procedure.

Note: All Surgeries (except when such Services are Medical Emergency Services) must be Pre-Authorized by the Plan Administrator.

Emergency Ground Ambulance

Limited to a one way trip when responding to a medical emergency where other means of transportation will endanger the patient's life or special medical equipment must be used en route to the closest medical facility available to provide the required level of care that results in an inpatient admission. Emergency ground ambulance transportation must be Medically Necessary. The use of ambulance Services for the convenience of an Insured Person, which are not Medically Necessary, will not be considered a Covered Service.

Outpatient Care

It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.

Urgent care clinic / facility

Services for non-critical but urgent care needs. You may be able to reduce your expenses and, in many cases, your wait time for care by using Convenience Care Clinic. All Convenience Care Clinics maintain extended weekday and weekend hours and treat non- Emergency conditions such as:

- Animal bites
- Cuts, scrapes and minor wounds
- Minor burns
- Minor eye irritations or infections
- Rash, poison ivy, or allergies
- Sprains, strains, dislocations and minor fractures

Outpatient ambulatory surgical facility & surgical care*

Surgeries that are deemed Medically Necessary. However, certain expenses will not be covered due to the following:

1. When multiple Surgeries are performed in addition to the primary Surgery, on the same or different areas of the body, during the same operative session, our payment will be based on 50% of the Allowable Charges for any secondary Surgery performed and is subject to the Cost Share amount (if any). This limitation applies to all bilateral Procedures and all Surgery Procedures performed on the same date of service.
2. Payment for incidental Surgery Procedures is limited to the Allowable Charges for the primary Procedure, and there is no additional payment for any incidental Surgical Procedure. An "incidental Surgical Procedure" includes Surgery where one, or more than one, Surgery is performed through the same incision or operative approach as the primary Surgery, which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the Surgical session.
3. Surgeon's fees for Medically Necessary Treatments related to Injury or Illness may be covered. However, follow-up visits for the first sixty (60) days following Surgery are part of the global fee charged by the Physician and are not reimbursable as a separate fee.
4. Outpatient Assistant Surgeon Fees are covered based on Medical Necessity and if the Surgery calls for an assistant as standard industry protocol and medical standards.
5. Benefits are provided for the Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered surgical procedure.

All Surgeries must be Pre-Authorized by the Plan Administrator.

Basic diagnostic services

It is recommended that these Services be performed in an In-Network Physician's office or in an In-Network free-standing facility, e.g., laboratory tests, x-rays, ultrasounds, EKG, colonoscopy, heart cardiac test, echocardiography, stress test *(this list is not exclusive)*. Basic diagnostic Treatment must be Medically Necessary for the Treatment or Diagnosis of an Injury or Illness. Our In-Network free standing facilities are conveniently located and provide Basic Diagnostic Services, Advanced Imaging/Diagnostic Testing and other Outpatient Services. For laboratory tests, visit Quest Diagnostics.

Advanced diagnostic and imaging services

It is recommended that these Services be performed in an In-Network free-standing facility, e.g., MRI, CT scans, PET scans, MRA, biopsy *(this list is not exclusive)*. All diagnostic Treatment must be Medically Necessary for the Treatment of an Injury or Illness. Our In-Network free standing facilities are conveniently located and provide Basic Diagnostic Services, Advanced Imaging/Diagnostic Testing and other Outpatient Services. For laboratory tests, visit Quest Diagnostics.

Outpatient Care

It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.

Outpatient therapeutic services

All Services must be Medically Necessary and relate specifically to the Physician's written Treatment plan, containing long term and short term goals. Therapeutic Services must produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time for the Services to be eligible for payment.

- **Physical Therapy**
  Physical Therapy Services is covered for the purpose of aiding in the restoration of normal physical function lost due to a covered Injury or Illness or to acquire or attain an age appropriate bodily function necessary to participate in Activities of Daily Living. Physical Therapy Services require a Physician's Treatment plan which must include the frequencies and duration of such therapy. Services must be rendered by a Physician or registered physical therapist, be Medically Necessary and relate specifically to the Physician's written Treatment plan.

- **Chiropractic Services**
  Chiropractic Services rendered by a Chiropractor for manipulation of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered. Spinal manipulation is a treatment modality or method and more than one spinal manipulation can occur and be billed during a single visit to a Provider.

- **Speech Therapy**
  Speech Therapy is covered for a condition resulting from Injury or Illness. Medical records must be provided to establish the Medical Necessity of the prescribed exercises and therapy for treating voice and speech disorders, and Treatment must be provided by a Physician or speech therapist. A Treatment plan including the frequencies and duration must be provided and approved by the Plan Administrator prior to the Treatment taking place. Speech therapy for speech impediments or developmental delays is not covered.

- **Occupational Therapy**
  Occupational Therapy is covered for a condition resulting from Surgery, Illness or Accidental Injury in order to:
  - Learn or re-learn Activities of Daily Living; or
  - Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of an Illness or Injury.

  Medical records must be provided to establish the Medical Necessity, and Treatment must be provided by a Physician or occupational therapist. A Treatment plan including the frequencies and duration must be provided and approved by the Plan Administrator prior to the Treatment taking place.

- **Vocational Therapy**
  Vocational therapy provides rehabilitation which enables the Insured Person with functional, cognitive, and health disabilities or impairments to overcome barriers to accessing, maintaining, or returning to employment or other useful occupation.

Not covered: maintenance therapy, speech therapy for speech impediments or developmental delays.

Outpatient oncology treatment*

Includes diagnostic tests, oncologist fees, Surgery, radiation therapy and chemotherapy alone or in combination from the point of Diagnosis. Radiation therapy must be rendered by a radiologist for proven malignancy or neoplastic diseases. Chemotherapy must be rendered by a Physician or Nurse under the direction of a Physician. Prescription Medication for Cancer treatments which have approved efficacy and market distribution will be covered subject to the Maximum Benefit amounts for Oncology Treatment. All Treatment must be Pre-Authorized by the Plan Administrator.

Outpatient reconstructive surgery*

As a result of a medical condition, Illness, Injury or Accident which first occurred while the Insured Person is covered under this Policy e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability. Reconstructive Surgery must be performed within twelve (12) months from the date of the Illness, Injury or Accident. This benefit is subject to Pre-Authorization in writing by the Plan Administrator.

Not covered: (i) Reconstructive surgery as a result of an Accident which did not first occur while covered under this Policy or not performed within the timeframe as specified under the terms and conditions of this Policy; or (ii) dental reconstructive surgery, microsurgery, replantation and plastic surgery.

Outpatient Care

It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.

Emergency dental treatment

Dental care Services are limited to an Accidental Injury of sound, natural teeth sustained while covered under this Policy. The Treatment must be received within 72 hours of the Emergency event (Accidental Injury does not include damage to teeth Incurred while chewing food or foreign objects) and you must provide proof of the Accident through a medical or police report.

Not covered: follow-up dental Treatment, dental Surgery, dental prostheses, orthodontics or periodontics.

Physician Services

It is recommended that these services be performed in an In-Network Physician's office or in an In-Network free standing diagnostic center to maximize your benefit and reduce your costs.

Primary care visit

One (1) visit per day per specialty for Treatment of an Injury or Illness. Includes physicians, osteopaths, general or family practitioner and gynecologist when designated as the primary care physician (who provides the first contact for an individual with an undiagnosed health issue). All Services conducted at a Physician's or Osteopath's office and billed as an office setting or Outpatient visit setting.

Specialist visit

One (1) visit per specialty for Treatment of an Injury or Illness. All Services conducted at a Physician's or Osteopath's office and billed as an office setting or Outpatient visit setting. Services must be medically indicated when your medical condition or diagnosis requires that you are treated by a physician with specific training for your condition or diagnosis.

Outpatient mental illness

Coverage is based on Medical Necessity. Outpatient Mental Illness consultation must be performed by a licensed Psychiatrist only. Visits and Treatment from a licensed practitioner with a master's degree or higher must be performed under the direct control of a Psychiatric Physician, psychologist, psychotherapist or other Specialist with appropriate qualifications in the field of psychiatry, psychotherapy or psychoanalysis and with the referral from a Psychiatric Physician which must be forwarded to the Plan Administrator prior to Treatment taking place. This Policy only covers generic medications prescribed to be administered on an Outpatient basis.

Not Covered: (i) Services for education or special education or job training whether or not given in a Facility that also provides medical or Psychiatric Treatment, Treatment for learning difficulties, hyperactivity, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, or any developmental and behavioral problems, any care for autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation which extends beyond traditional medical management or for environmental or social change; (ii) Inpatient (overnight) mental health Services received in a residential treatment facility; (iii) primal therapy, bioenergetic therapy or psychodrama; or (iv) Services for, or in connection with marriage, family, child, career, social adjustment or behavioral, pastoral, bereavement or financial counseling.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hypo-sensitization serum may be covered. The Allowable Charges are based on the following conditions:

1. This Policy will only cover office-based skin tests (in vivo testing) and treatment for a condition that first manifests itself during the Policy Period and for a medical condition that has not been previously diagnosed.
2. Allergy testing or treatment and the frequency of allergy testing and/or Treatment must be Medically Necessary and ordered by a Physician specializing in allergies.

Not covered: Treatment that is Experimental in nature. Allergy Treatment, as described above, will not be covered if a medical condition has not been diagnosed as a result of the allergy testing.

Medication Program

Prescription Drug Benefits

In the United States, coverage for Outpatient Prescription Drugs and Supplies listed in our Medication Guide when dispensed by a participating pharmacy in the network of our Pharmacy Benefit Manager (PBM). This Policy covers Generic and certain Brand medications. Generic will always be dispensed under this benefit. Certain Brand medications will only be dispensed when the following requirements are met: (a) be Medically Necessary; (b) requested when Generic is not available; and (c) specifically ordered by a Physician in place of the Generic medication. If a Brand medication is prescribed for a Generic equivalent, the maximum benefit of $250 will apply to the Brand medication. If the Generic medication is available or exists, this Policy will pay for Brand medication up to the equivalent cost of the Generic medication. The use of biosimilars (the preferred therapy based on step therapy requirements) must be exhausted first before a Brand medication is prescribed. In certain circumstances, Pre-Authorization may be required. The Medication Guide is subject to change at any time. The most up-to-date information about modifications to the medications listed in the Medication Guide can be found by contacting your ConciergeCare Counselor.

Covered Prescription Drugs & Supplies

A Prescription Drug is covered only if it is:

1. Prescribed by a Physician or other health care professional (except a pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a pharmacist who is certified in immunization administration;
2. Dispensed by a pharmacist acting within the scope of his or her license;
3. Medically Necessary;
4. A Prescription Drug contained in an anaphylactic kit, such as Epi-Pen, Epi-Pen Jr., Ana-Kit;
5. Authorized for coverage by us, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
6. Not specifically or generally limited or excluded as stated in this Policy; and
7. Approved by the applicable regulatory body in the United States, the FDA and assigned a National Drug Code.

A Supply is covered under this section only if it is:

1. A covered Prescription Supply;
2. Prescribed by a Physician or other health care professional (except a pharmacist) acting within the scope of his or her license;
3. Medically Necessary; and
4. Not specifically or generally limited or excluded as stated in this Policy.

Note: certain generic oral contraceptives (30-day supply) or an implantable (one per lifetime) may only be covered when using the In-Network Medication Program and purchased through an EHIM contracted pharmacy.

Not Covered: (i) any Prescription Drug filled in excess of the quantity limit or day supply limit covered by this Policy; (ii) any Prescription Drug refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order; (iii) Compounded Prescription Drugs that do not contain at least one (1) ingredient that has been approved by the FDA and requires a prescription for refill; (iv) Compounded Prescription Drugs that are available as a similar commercially available Prescription Drug; (v) any product for which the primary use is a source of nutrition or dietary management of disease, even when used for the Treatment of an Illness or Injury; (vi) vitamins, minerals, herbs, supplements, aspirin, cold remedies, special infant formula, and any other over the counter medicine or medical Supply even if medically recommended, prescribed or acknowledged as having therapeutic effects; (vii) medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; (viii) Prescription Drugs refilled before 85% of the previous filling has been used; (ix) Prescription Drug scripts or orders that are forged or otherwise wrongfully obtained; (x) growth hormones; (xi) hormone therapy treatment; (xii) contraceptive intrauterine device, diaphragm, ring and injectable (only generic oral contraceptives for a 28 or 30-day supply and one implantable per year are covered under this Policy); (xiii) smoking cessation medications; (xiv) retinoids such as Retin-A and their generic or therapeutic equivalents; (xv) certain Prescription Drugs and Supplies that require prior authorization in order to be covered; (xvi) Specialty Drugs; and (xvii) Out-of-Network pharmacy.

Maternity Care and Birth Benefits

Maternity care*

This benefit provides coverage for costs associated with well mom and well baby (both go home on the same day), for a normal delivery, Cesarean section (*medically necessary*), Complications of Pregnancy, including, but not limited to, Hospital, professional and nursery fees for mother and newborn (as applicable), obstetrician fees or midwife fees, routine child birth, prenatal and postnatal care. Complete medical records must be provided to the Plan Administrator in order to confirm Eligibility for this benefit. Benefits for Maternity Care shall include the Services of a certified Nurse-midwife under qualified medical direction; however, we will not pay for duplicative routine Services actually provided by both a certified Nurse-midwife and a Physician. Routine maternity stay is two (2) days for a vaginal delivery and four (4) days for a Cesarean section. This does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). Your Provider is required to obtain authorization for prescribing an Inpatient Hospital stay that exceeds 48 hours (or 96 hours). The Hospital is required to file one claim which combines the baby's charges with the mother's charges.

Limitations:

1. The Dependent spouse (if Dependent coverage is provided under this Policy), may not be pregnant at the time of enrollment and pregnancy must occur after the first ten (10) months of the Policy Period. No coverage will be provided for the Dependent spouse for any Treatment or Services related to pregnancy, or any Complications of Pregnancy, including delivery which arise during the first ten (10) months of the Policy Period.
2. 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.
3. 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.
4. This benefit is also subject to the timely filing clause stated in the terms and conditions.
5. It is recommended that Services be rendered by an In-Network Physician or In-Network Provider.
6. Eligible charges related to Hospital nursery and professional Services for the newborn must be combined with the mother's bill (UB92) and submitted as one claim

Not Covered: (i) elective C-sections; (ii) pregnancies arising out of fertility treatment (such as IVF), assisted conception, any pre-birth or in-utero Procedures and any Complications of Pregnancy arising directly or indirectly therefrom; (iii) pregnancy of a Dependent daughter; (iv) post-natal classes following birth to deal with the physical effects on the body of being pregnant and giving birth; (v) the cost or refund of Treatments relating to surrogacy, whether you are acting as a surrogate or are the intended parent; (vi) circumcision; (vii) any Services, Procedures, Treatments or Surgeries related to Congenital Conditions in a newborn, whether or not associated with a covered pregnancy.

Non-healthy newborn infant care*

This benefit provides coverage for Hospital Services and medical care provided for a sick newborn infant in the Hospital (not related to the Treatment of Congenital Conditions). This benefit is only available to infants born of a covered pregnancy under this Policy and the newborn is added to the Policy within 30 days of the birth. Coverage 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 effective as of the newborn infant's date of birth as long as the infant is enrolled within thirty (30) days from date of birth.

Not covered: circumcision, unless Medically Necessary and Pre-Authorized by the Plan Administrator.

Habilitative Services for the Treatment of Congenital or Genetic Birth Defects*

Benefits will be paid the same as any other Illness for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects for an Insured Person up to age 21. This benefit is only applicable to Dependent children born under a covered pregnancy. For the purposes of this benefit, Congenital or Genetic Birth Defect means a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder or cerebral palsy. Habilitative Services include occupational, physical, and speech therapy for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the individual's ability to function.

Elective Medical Abortion*

Coverage may be provided for a medication, aspiration or D&E abortion depending on how many weeks the woman is into her pregnancy. A woman is eligible for a medication abortion (the abortion pill) if she is less than 10 weeks into her pregnancy. If a woman is 10 weeks up to 15 weeks into her pregnancy, she can have an aspiration abortion, while D&E abortions are typically performed at 15 weeks or after. Benefits are provided for elective abortions if performed at a licensed facility and meet the guidelines of the state where performed.

Other Services

Alcohol and Substance Abuse* *(rehabilitative only)*

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

Not covered: Treatment for any Injuries or Illnesses caused by, contributed to or resulting from the Insured Person's voluntary use of alcohol, illegal drugs, poison, gas or fume, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured Person's Physician.

Home Health Care*

Home Health Care Services may be covered when all the following criteria are met:

1. You are unable to leave your home without considerable effort and assistance because you are bedridden or chair-bound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. The Home Health Care Services rendered have been prescribed by a Physician by way of a formal written Treatment plan to us;
3. The Treatment plan has been reviewed and renewed by the prescribing Physician at least every thirty (30) days until benefits are exhausted. (We reserve the right to request a copy of any written Treatment plan in order to determine whether such Services are covered);
4. The Home Health Care Services are provided by or through a Home Health Agency; and
5. You are meeting or achieving the desired Treatment goals set forth in the Treatment plan as documented in the clinical progress notes.

To obtain benefits, an Insured Person must meet all of the following conditions:

1. A Insured Person would have to be admitted to a Hospital or Skilled Nursing Facility if he or she did not receive Home Health Care Services;
2. The Home Health Care Services program must be directly related to the Condition for which hospitalization was required; and
3. The Insured Person has been admitted as in Inpatient in the Hospital for at least three (3) consecutive days and the Home Health Care Services program must begin within three (3) days of discharge from the Hospital or Skilled Nursing Facility.

Home Health Care Services are limited to:

1. Part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse or a vocational Nurse under the supervision of a Registered Nurse, and/or home health aide Services (part-time is defined as less than 8 hours per day and less than 40 hours per week and an intermittent visit will not exceed 2 hours per day);
2. Home health aide Services must be consistent with the plan of Treatment, ordered by a Physician, and provided under the supervision of a Registered Nurse;
3. Medical social Services;
4. Nutritional guidance;
5. Respiratory or inhalation therapy, such as oxygen; and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Not Covered: Homemaker or domestic housekeeping services.(care must begin immediately following your hospital stay of no less than 3 days, ordered by a physician and provided under the supervision of a registered nurse).

Diabetic Medical Supplies

Diabetic Medical Supplies are provided for certain diabetic Supplies including insulin pumps and associated Supplies. Diabetic Medical Supplies may be covered through the EHIM In-Network Pharmacy or your Durable Medical Equipment benefit.

Other Services

Durable medical equipment

Therapeutic aids, appliances or other equipment that help you to complete your daily activity and can withstand repeated use. The following criteria must be met:

1. Prescribed by a Physician;
2. Customarily and generally useful to a person only during an Illness or Injury; and
3. Determined by us to be Medically Necessary.

The therapeutic aids and appliances that may be covered as an Outpatient Treatment include: orthopedic braces for the arm, neck, leg and back; bandages; trusses; walking aids; compression stockings; corrective splints; plaster shells for lying and sitting. We will only cover the therapeutic aids and appliances as follows: wheelchairs, cardiac and respiratory monitors, infusion pumps, inhalation devices, oxygen devices, monitors for newborn babies, and speaking aids (electronic larynx). If the device or appliance is not listed above, it does not qualify as therapeutic aids and appliances and will not be covered. The covered amount is based on the Usual, Reasonable and Customary Charges for the DME, which meets the Insured Person′s basic medical needs. The Allowable Purchase Price of the DME must not exceed the rental fees and Insurer will determine, in its sole discretion, if the DME is purchased or rented.

Not Covered: motor driven wheelchairs; beds; additional wheels; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable Supplies; exercycles; sun or heat lamps; heating pads; bidets; toilet seats; bathtub seats; sauna baths; elevators; whirlpool baths; exercise equipment or similar items; or the cost of instructions for the use and care of any such durable medical devices. The customizing of any vehicle, bathroom facility, or residential facility is also excluded.

Worldwide Coverage

(outside the United States)

If the Policyholder is an **F1 Visa holder** and: (i) travels during a college/university scheduled winter, spring or summer break; or (ii) enrolls in a study abroad program *(outside the United States and excluding his/her Home Country),* which is sponsored by the student's college or university; this Policy will provide worldwide coverage for the duration of the travel or the study abroad program, as applicable *(the student will be required to provide documentation of the study abroad enrollment and any other relevant documentation requested by Insurer*).

If the Policyholder is a **J1 Visa holder** and travels during a college/university scheduled winter, spring or summer break, this Policy will provide worldwide coverage for a maximum duration of thirty (30) days; provided, (i) the Policyholder must provide documentation that the absence from the United States has been approved by his/her sponsor; and (ii) the Policyholder's covered Dependent(s), if any, must travel with the Policyholder and shall not remain in the United States if the Policyholder is absent.

Services provided outside the United States (*excluding the Restricted Areas*), are covered per Insured Person for those Services stated in the section titled "What Your Plan Covers." Your Copayment and Coinsurance (Cost Share) amounts will be the same as your In-Network Cost Share amounts in the United States for the Insured Person. All Services must be Medically Necessary. All benefits are subject to Usual, Reasonable and Customary Charges *(for Home Country are subject to the Maximum Benefit amount and duration stated in the Summary of Benefits)*. We will attempt at all times to settle the costs directly with a Provider; however, it is in the Provider's discretion to accept direct payment from us. In the event a direct settlement is not accepted by the Provider, the Insured Person must settle the invoices in full directly with the Provider. The Insured Person may submit the invoices for reimbursement; provided, however, reimbursement will be in the amount of the Usual, Reasonable and Customary Charges for such Services. All reimbursement requests must be done in accordance with this Policy.

What Your Plan Does Not Cover

Exclusions and Limitations

The Exclusions and limitations set forth in this section are in addition to any that are specified in the section titled "What Your Plan Covers." We will not pay for any of the Services, Treatments, Procedures, Prescription Medications or Supplies described in this section, even when recommended or prescribed by a Physician, court ordered, or in the event it is the only available Treatment for your condition. We will not cover any Services, Treatments, Procedures, Prescription Medications/Drugs or Supplies:

1. **General Exclusions:**
   - (i) not specifically listed in this Policy as covered.
   - (ii) for any complications directly caused by an Illness, Injury or Procedure for which we exclude or limit coverage.
   - (iii) for Professional Services received from a person who lives in the Insured Person's home or who is related to the Insured Person by blood, marriage or adoption including, guardian, domestic partner or non-marital partner or at a Facility owned partially or completely by the aforementioned persons.
   - (iv) where Treatment or Advice of a medical condition, whether related or not, was a result of self-treatment or auto therapy (self-administered).
   - (v) that arise from, are related to or associated with specific medical Advice which has been disregarded (including travel where an Insured Person has traveled against medical Advice), any changes in Prescription Drugs, therapies or diet that are a result of a previously known condition that can affect degrade or alter the Insured Person's health, or any Services, Procedures or Treatment that is abandoned against medical advice.
   - (vi) not ordered, recommended, or approved by a Physician.
   - (vii) not rendered under the scope of a Physician's license.
   - (viii) not Medically Necessary or in accordance with established Evidence Based Medicine will not be covered.
   - (ix) rendered in the Insured Person's Home Country unless otherwise covered under the section titled "What Your Plan Covers."
   - (x) Claims and costs for medical Services or Prescription Medication/Drugs occurring before the Policy Effective Date or with dates of Service after the Policy expiration/termination date will not be covered.

2. **Fertility and Infertility Treatments:** (i) that promote conception including, but not limited to, fertility/infertility drugs, any Prescription Medications, or any complications directly or indirectly related thereto; or (ii) to prevent pregnancy (*other than certain contraceptives stated in the Outpatient Prescription Medications benefit*) or which is aimed at making a person unable to reproduce, including, but not limited to, vasectomies, sterilization, male contraception and any expenses for male or female reversal of sterilization.

3. **Sexual Dysfunction and Sex Change Services:** (i) for sexual dysfunction, impotency or inadequacies, including sexual enhancement drugs; or (ii) hormone therapy to change the biological sexual characteristics to those of the opposite sex, implantation or sexual transformation.

4. **HIV/AIDS/STDS:** (i) related to HIV or any and all sexually transmitted diseases, or complications directly or indirectly related to the same, including circumcision; (ii) any associated diagnostic tests or charges for HIV infection, seropositivity to the AIDS virus, AIDS related Illness(es), ARC Syndrome, AIDS, and all diseases caused by and/or related to HIV or arising as complications from these conditions including, but not limited to the cost of testing for these conditions and/or charges for drug Treatment(s) or surgeries; or (iii) voluntary HIV screening.

5. **Dental, Vision and Hearing Care (*adult and children*):** (i) dental, orthodontic or dental cosmetic Services, Treatments or Procedures unless covered under the Emergency Dental Treatment benefits in What Your Plan Covers (ii) temporomandibular malocclusion joint disorders; (iii) routine eye examinations, eyeglasses, contact lenses, sunglasses, fitting of frames or contact lenses, or any vision correction surgery; or (iv) routine hearing examinations (*except as covered under Well Childcare*), hearing aids or devices, Surgical implantation of, or removal of bone anchored hearing devices, and cochlear implants.

6. **Podiatric Care:** routine foot care, including the paring and removing of corns, calluses, or other lesions, or trimming of nails, Treatment of hammer, claw and mallet toes, structural and functional Treatment of the feet, Treatment of weak/fallen arches, weak, strained or flat feet, bunions, any Symptomatic complaints of the feet, congenital foot disorders, or any foot Treatment resulting from an Illness or Injury. Orthopedic shoes, orthotic or other supportive devices or inserts of any kind, or any other preventative Services or Supplies are also excluded from coverage.

7. **Genetic Testing and Screening:** any genetic testing or screening including, but not limited to, BRCA1, BRCA2, cystic fibrosis, or genetic counseling, Treatment related to genetic medicine or linked to an inheritable disease, and preventative prophylactic surgeries recommended by genetic testing or screening.

8. **Therapeutic Services:** (i) stays in a cure center, a bath center, a spa, a health resort or a recovery center, even if they are medically prescribed. This also includes thermal baths, saunas and any kind of wellness massages; or (iv) Rolfing; carbon dioxide therapy; aroma therapy; bio-electromagnetic therapy; magnetic therapy; vitamin therapy; nutritional consultations; naturopathic medicine; ayurvedic medicine; biofield therapies; energy medicines; color puncture; light therapy; hypnotherapy; reflexology; spiritual healing; Ti-chi; traditional oriental medicine; or chelation therapy. We do not recognize nutriments, tonics, mineral water, cosmetics, hygiene and body-care products and bath additives as Medically Necessary and these items are not covered.

9. **Coverage Under Other Plans or Sources:** provided by or payment is available from: (i) workers' compensation law, occupational disease law or similar law concerning job related conditions; (ii) an Other Insurance Plan or governmental program; or (iii) under the direction of public authorities related to epidemics and pandemics.

10. **Elective and Cosmetic Surgeries, Treatments and Procedures:** (i) any elective and/or cosmetic Service, Surgery, Procedures, Treatments, technologies, Prescription Drugs, devices, items, products, and Supplies that are not Medically Necessary, whether or not due to a covered Injury or Illness or for psychological purposes, and that may only be provided for the purpose of improving, altering, enhancing, or genetically manipulated the quality of an existing condition; and (ii) any complications arising directly or indirectly therefrom.

11. **Breast Reduction or Augmentation:** for breast reductions or augmentation, regardless of a Physician's recommendation of Medical Necessity, or any Treatment or complication related to or arising from breast implants, even if due to an Accident (except in connection with breast Reconstructive Surgery after a mastectomy).

12. **Skin Conditions:** acne, rosacea, skin tags, and any other Treatment to enhance the appearance of the skin.

13. **Nasal Surgery:** deviated septum, submucous resection and/or other surgical correction thereof, nasal and sinus Surgery except for Treatment of a covered Injury.

14. **Weight Related Services:** (i) weight reduction and the cost of all Surgical Procedures, Treatments, Supplies, Services or Prescription Medication for weight reduction, appetite suppression, dietary counseling, weight reduction programs, morbid or non-morbid obesity, medical fast diets, weight loss programs or complications arising directly or indirectly from the same.

15. **Sleep Studies and Disorders:** sleep studies, investigations for insomnia, sleeping disorders, and other Treatments relating to sleep apnea, jet lag, fatigue, or stress or any related conditions.

16. **Illegal Activities:** Injuries and Illnesses resulting, arising from or occurring during the commission or perpetration of a violation of law by an Insured Person.

17. **Services for Administrative Purposes:** health check-ups, Services or visits, inoculations, immunizations or related tests or Services if necessary for administrative purposes (e.g., determining insurability, employment, school or sport related physical examinations, travel etc.).

18. **Organ Transplants:** Organ Transplants and related Procedures including, but not limited to: (i) expenses for the acquisition of an Organ including, but not limited to, donor searches, typing, harvesting, transportation and administration costs; (ii) supportive Services; (iii) all expenses of cryopreservation and the implantation of living cells on a deceased person or in conjunction with infertility or reproductive Treatments; (iv) Transplant that includes artificial mechanical equipment or

artifacts designed to replace human organs; (v) any medication or therapeutic Treatments required to secure and maintain the health of the transplanted Organ; or (v) animal organs.

19. **Alternative Medicine:** any Services including but not limited to acupuncture, acupressure, homeopathy, and Chinese herbs.

20. **Hospice:** any Services, Procedures or Treatments related to palliative or supportive Services for a terminally ill Insured Person or other hospice related Services.

21. **Therapeutic Termination of Pregnancy:** any Services, Procedures or Treatments related to therapeutic termination of pregnancy and any complications related thereto.

22. **Congenital Conditions:** any Services, Procedures, Treatments or Surgeries related to Congenital Conditions with the exception of Habilitative Services for Congenital Conditions as stated in the section titled "What Your Plan Covers."

23. **Experimental and/or Investigational Services:** determined by Insurer to be Experimental and/or Investigational. The Plan Administrator's decision, whether a Prescription Drug or its use is "investigational" or "experimental" shall be binding.

24. **Sports and Hazardous Activities:** (i) participating in or providing instruction for Intercollegiate, Interscholastic Intramural, Club Sports or semi or Professional Sports or competitive sports, including cheerleading; traveling to or from such sports, contests or competition as a participant; or while participating in any practice or conditioning program for such sport, contest or competition; (ii) hazardous or extreme sports or activities, any deliberate exposure to exceptional danger, or any sport that requires a higher degree of knowledge or training including, but not limited to, bungee jumping; sky diving; skiing (off groomed trails), snowboarding (off groomed trails); mountain climbing (with or without the use of ropes); diving to depths greater than 15 meters/50 feet *(certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required)*; flying within 24 hours of a diving activity; whitewater rafting (level 3 and higher); motorsport activities including racing or contests; hang-gliding; paragliding; parachuting; racing by any animal, spelunking, parasailing, or flight in any kind of aircraft either as a pilot in command, student pilot, sport flying or the business or trade of flying (except while traveling as a passenger in a fully-licensed passenger carrying aircraft); (iii) the use of any type of firearms (any device that discharges a projectile of any type); (iv) motorcycles; mopeds; scooters; any one, two or three wheeled motorized vehicle (including ATVs); sport watercraft such as wave runners, jet skis; racing or speed testing any motorized vehicle or conveyance; or any other powered devices whether the vehicle is in motion or not.

25. **Motor Vehicles:** (i) the use of a motor vehicle by the Insured Person unless the Insured Person is carrying a legally issued driver's license and insurance from the country in which he/she is an eligible Policyholder; (ii) Incurred medical expenses resulting from a motor vehicle accident if such expenses are recoverable under Other Insurance, including any "No Fault" automobile insurance contract regardless of whether the Insured Person asserts his/her rights to obtain benefits from these sources will not be covered; or (iii) the operating of any type of vehicle or conveyance while under the influence of alcohol, illegal drugs, poison, gas or fumes, any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured Person's Physician, or drugs or medicines for which the Insured Person was provided a written warning against operating a vehicle or conveyance while taking it.

26. **Evacuation and Repatriation**: related to Emergency Medical Evacuation (including, but not limited to, any accommodation fees, travel tickets, taxis or any other transportation costs) Repatriation following an Emergency Evacuation, Companion Coverage, Bedside Visit and/or Repatriation of Mortal Remains benefits are excluded.

27. **War and Terrorism:** Illnesses and Injuries, and their consequences, as well as the consequences of Accidents and deaths caused by the following: (i) martial law or state of siege, or any event or causes which determine the proclamation or maintenance of martial law or state of siege; (ii) foreseeable acts of war or any act of war, declared or undeclared; (iii) civil unrest, or involvement in civil commotion or an illegal act, mutiny, riot, strike, military or popular uprising, insurrection, rebellion, military or usurped power; including resultant imprisonment; (iv) any act of any person acting on behalf of or in connection with any terrorist organization; (v) criminal acts unless the Insured Person suffers an Injury as a non-involved third party who has not put themselves in danger in a deliberate or negligent way and such Injury has not been paid or is not payable by a state crime victims compensation program or similar type of governmental program which reimburses victims for crime-related expenses. We will not provide coverage if the Insured Person moves to a territory where direct combat is taking place or provides services for any of the parties involved in that conflict; or (vi) Illnesses, Injuries and Accidents,

directly or indirectly, as well as their consequences, which have been caused by nuclear energy (nuclear reactions, radiations, and contamination, asbestosis or any related condition), as well as Illnesses, Injuries and Accidents, as well as their consequences caused by chemical or biological weapons.

28. **Foreseeable Events/Restrictions on Travel:** (i) that arise from, are related to or associated with, an actual or likely contagious disease, epidemic or pandemic, the threat of a contagious disease, epidemic or pandemic or any foreseen event. This exclusion is designed to exclude losses caused by reasonably foreseeable events. The moment an event becomes a foreseen event, it will not be covered; (ii) that arise from, or are associated with, travel to countries or parts of a country for which: (a) an advice or warning has been released by any governmental or official body, the Federation of European Risk Management Association, the US Government Department of Foreign Affairs and Trade, or the US Centers for Disease Control and Prevention, and the advice or warning risk rating is "reconsider your need to travel" or "do not travel" (or words to that effect) or the advice or warnings advise against all non-essential travel to or in that location or advise against specific transport arrangements or participation in specific events or activities; or (b) the mass media has indicated the existence or potential existence of circumstances (including circumstances referred to in clause (a) above that may affect your travel, and you did not take appropriate action to avoid or minimize any potential claim under your Policy (including delay of travel to the country or part of the country referred to in the relevant advice(s), warning(s) and/or mass media statement(s)).

Who May Be Covered, When and How Your Coverage Begins

Who May Be Covered

Eligibility Requirements for Policyholder

F1 requirements:

(i) you are a full-time student enrolled in either: (a) an accredited educational program or in an associate, bachelor, master, or Ph.D. program at a university or other recognized higher education institution; (b) a language-training program; or (c) a vocational program; or

(ii) you are a full-time visiting faculty, scholar or other person engaged in research activities (as defined by the educational institution). Students must actively attend classes. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend class.

J1 requirements:

(i) you are taking part in work-and-study-based exchange and visitor programs in the United States which are sponsored by an educational or other nonprofit institution, and is accredited through the Exchange Visitor Program designated by the U.S. State Department; and

(ii) you must come to the United States to teach, study, receive training, or demonstrate special skills whereby such training is not available to you in your home country, and the training must be directly related to your academic program.

Additional requirements:

(i) you must be between the ages of 17 and the attained age of 45 at the time of application.

(ii) you must be residing outside your Home Country and you must remain engaged in full-time educational or research activities outside your Home Country during the Policy Period. You are ***not*** eligible for this Policy if your intent is to live in a fixed location outside your Home Country (living abroad versus traveling).

(iii) you must not have obtained residency status in the United States.

(iv) you must hold a valid passport and a valid F-1 or J-1 visa. An F-1 visa holder on OPT is not eligible for this Policy. Policyholder must, at all times during the Policy Period, meet all the specific requirements and regulations of the applicable US visa that has been obtained to enter the United States. As an Insured Person with an F-1 Student Status, Form I-20 will be provided to you by your school which you and your school official must sign. As an Insured Person with a J-1 Status, Form DS-2019 will be provided to you which you and your school official must sign. We may request a copy of the I-20 or DS-2019 and your current visa.

(v) you must be in good health and not confined to a Hospital or nursing home, hospitalized or disabled as of the Policy Effective Date.
(vi) Students under the age of 18: the parent or legal guardian must complete the documentation with the applicable sponsoring organization as follows:
- Parental authorization form completed and signed by the parent or guardian.
- Vaccination agreement.
- Student-parent agreement form completed and signed by the student and the parent or guardian. The parent or legal guardian is required to sign the application and purchase the policy on behalf of the student.
- Student application completed and signed by the student and the parent or guardian.
- Student behavior agreement.
- If the Policyholder is also eligible as a Dependent under a different policy, he/she may only be covered once under a Policy.

WellAway 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.

Eligibility Requirements for Dependents

(i) your spouse or domestic partner and/or eligible children may be eligible for coverage under this Policy under a Dependent or companion visa. Please check the US Department of State requirements to determine if your family member is eligible.
(ii) Dependent must be the Policyholder's legally married spouse up to age 41 or unmarried child under the attained age of 19 years and chiefly dependent on the Policyholder for support and maintenance.
(iii) Dependent must accompany the Policyholder abroad on a similar visa or passport while the Policyholder engages in the international educational activities.
(iv) Dependent must be temporarily located outside the Policyholder's Home Country.
(v) Dependent must not have obtained residency status in the United States or be a US citizen.
(vi) Dependent children over the age of nineteen years are no longer eligible and coverage for such Dependent will automatically terminate upon the Dependent reaching the attained age of 19.
(vii) In no event will a Dependent be eligible if the Policyholder is not eligible.
(viii) Dependent children are not eligible for Maternity Care and Birth Benefits.

WellAway has the right to investigate eligibility status. If it is discovered the eligibility requirements are not met, the insurance coverage will be terminated.

Termination of Eligibility

Every exchange visitor is subject to the laws, rules and regulations of the US government and the Program Sponsor. This means that a violation of any of the rules or regulations established by either of these two entities could mark the end of an Insured Person's stay in the United States. There are several other reasons that could lead to visa early termination including, but not limited to:

- failure to pursue the activities for which you were admitted to the United States;
- inability to continue your program;
- engaging in unauthorized employment;
- extending the time in the US beyond the total amount indicated by the program; or
- conviction of a crime.

In the event the Policyholder's visa status is terminated before the end of his or her program in the United States, all Insured Persons under the Policy will be terminated.

How and When to Enroll a Newborn Baby or Adopted Child

Newborn babies and legally adopted children (a copy of the legal adoption agreement is required) may be covered, without qualifying periods, upon the Insurer's receipt of a Certificate of Birth, if the Policyholder is covered by this Policy prior to the newborn's birth or the date of the adoption and is added to this Policy within thirty (30) days of the newborn's date of birth or the date of adoption. Any request received beyond the thirty (30) day notification period will be subject to the following: the effective date of coverage will be the date of the notification to add the newborn or adopted child; and coverage: (i) is not guaranteed; (ii) is subject to a Certificate of Wellness; and (iii) the maximum benefit amount during the first (30) days of life is $5,000. The newborn or adopted child will be enrolled under the same coverage as the Policyholder, coverage will be based upon the terms and conditions of this Policy and is subject to the payment of the additional Premium for the newborn or adopted Dependent.

When Your Coverage Begins

A Policyholder's coverage takes effect on the date stated in the Certificate of Coverage as the Effective Date and the Premium has been paid. Dependent's coverage takes effect on the same day that the Policyholder's coverage becomes effective, if you have enrolled a Dependent in the plan by then and the corresponding Premiums have been paid. Dependents can only be covered if the Policyholder is covered by the Policy and has elected Dependent coverage. The period of coverage for an Insured Person is referred to as the Policy Period in this Policy and such coverage will end at midnight on the date indicated in the Certificate of Coverage. If an Insured Person was repatriated back to his/her Home Country, coverage will terminate upon the Insured Person's departure from the United States. Termination of the Policyholder's coverage also terminates coverage for his/her Dependents. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met.

Minimum and Maximum Policy Period Duration

The period of coverage for this Policy is January 1, 2023 through July 31, 2023. The minimum Policy Period for an Insured Person must be the entire duration the Policyholder actively attends classes or is engaged in the visa approved activity. This Policy will not cover any Insured Person after July 31, 2023, except for the Policyholder in the event of an Extension due to Hospitalization of Policyholder, as set forth below.

Extension due to Hospitalization of Policyholder

In the event the **Policyholder** is confined to a Hospital which extends beyond the termination date of the Policyholder's Policy, the insurance coverage may be extended for the Policyholder *(and not for any other Dependent covered under the Policy*) provided:

(i) WellAway is notified in writing of the request at such time that the Policyholder is Hospitalized; and
(ii) the appropriate documentation has been submitted to and approved by WellAway.

WellAway will cover the Policyholder's medical expenses beyond the original Policy Period subject to the following:

(i) for a maximum period not to exceed thirty (30) days.
(ii) subject to the terms, conditions and Maximum Benefit amounts stated in this Policy.
(iii) for the sole purpose of stabilizing medical Treatment. No additional coverage will be provided for an unrelated Illness, complications or a secondary diagnosis.
(iv) Insured Person has not purchased another health insurance policy. Coverage under this Policy cannot be combined with any other policy to exceed benefit limits.
(v) coverage does not apply to any Dependents or a child born from a covered pregnancy under the Policy after the termination date of the Policy.

Coverage Under Extended 30-day Grace Period

Certain Insured Persons (*depending on the type of visa*) may enter the United States up to thirty (30) days before the program start date or stay in the United States up to thirty (30) days after the program end date.

- **New Students**: Coverage 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 - up to thirty (30) days prior to the program start date. In order to be eligible, a new student must have enrolled in full-time studies at a higher education institution, notified WellAway in writing of the request at least five (5) days prior to the departure date to the United States and paid the applicable Premium (prevailing rates will apply at the time of the request and cannot be combined with any other policy to exceed benefit limits). Coverage will be effective on the first day the new student arrives in the United States (*but not more than 30 days prior to arrival*) and has complied with this provision.
- **Existing Students**: Existing students (Policyholder) who have completed their final term of study in the United States and are preparing to return to his/her Home Country may extend coverage for up to thirty (30) days after the program end date. In order to be eligible, the Policyholder must notify WellAway in writing of the request at least five (5) days prior to the expiration date of the current Policy Period and pay the required Premium (prevailing rates will apply at the time of the request and cannot be combined with any other policy to exceed benefit limits). Coverage will terminate on the Policyholder's date of departure from the United States (*but not more than 30 days following the Policyholder's program end date)*.
- **Short Term Programs**: In the event the student's entire program of study is less than sixty (60) days, the applicable Coverage for a Grace Period will be limited to seven (7) days. All other benefit provisions will apply as indicated herein.
- Grace Period Coverage does not apply to Policyholders who are continuing their studies or returning to studies in the United States whether at the same or different institutions.
- Grace Period Coverage will not be approved in conjunction with the expiry of another policy.
- Grace Period Coverage is not permitted if the student's intent is to live in a fixed location outside his/her Home Country (living abroad versus traveling).

How Your Coverage Works

Pre-Authorization

Certain Services require Pre-Authorization and we always recommend that you use an **In-Network Physician and an In-Network Facility** in order to minimize your costs. Pre-Authorization is a process by which an Insured Person obtains approval for certain non-Emergency medical Services prior to the commencement of the proposed Service. Please contact our ConciergeCare team to request a Pre-Authorization at least five (5) business days prior to the scheduled Service, unless a greater time period is required as stated in this Policy. When you contact us for Pre-Authorization, we will recommend that you use an In-Network Physician and an In-Network Facility within the Network. Complete medical records must be submitted to our Plan Administrator for review of Medical Necessity in accordance with the terms of this Policy. A cost Estimate of the Services will also be required at the time of the request for Pre-Authorization for any Services. ***Please refer to What Your Plan Covers for all Services and Procedures that require Pre-Authorization (which are indicated by an asterisk).***

The following Services require Pre-Authorization (*Services in the section titled "What You Plan Covers" that require Pre-Authorization are indicated by an asterisk**):

- Any Hospitalization
- Outpatient or Ambulatory Surgery
- All Cancer Treatment (including chemotherapy and radiation)
- Maternity and Birth Benefits
- Alcohol and Substance Abuse
- Home Health Care
- Prescription Medications in excess of $250 per prescription
- Any condition, which does not meet the above criteria, but is expected to accumulate over $10,000 of Services per Policy Period

If we have not provided Pre-Authorization, you may be subject to the following:

(i) a 30% penalty (*for covered Services)* for the entire episode of care, which will not apply towards your Out-of-Pocket Maximum.

(ii) If the Service would not have been approved under this section, denial may apply to all Services including, but not limited to, Hospitalization, Procedures, Treatments, and Physician fees.

Notification of Medical Emergency Services must be received by the Insured Person, or someone acting on behalf of the Insured Person, within 48 hours of an Admission or Procedure. In the event of an Emergency, the Insured Person should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the Network.

Pre-Authorization approval does not guarantee payment of the claim (*covered benefits are subject to eligibility at the time charges are actually incurred and all other terms, limitations, and exclusions of this Policy)* ***and the Insured Person is responsible for any Deductible, Coinsurance and Copayment amounts, as applicable.*** The use of an In-Network Physician and an In-Network facility will keep your Out-of-Pocket expenses to the lowest possible amount.

Deductible

You may have chosen a plan with a Deductible to help you reduce the cost of your coverage. There is only one Deductible per Insured Person per Policy Period. You must pay the amount of the Deductible during each Policy Period before we provide coverage. After the individual Insured Person pays the Deductible, the plan covers Allowable Charges (In-Network) or Usual, Reasonable and Customary Charges (*Out-of-Network*) of the Covered Expenses subject to Copayments, Coinsurance, any Maximum Benefit amounts and Policy Period Maximum amounts.

The following charges will not apply towards your Deductible and when you have reached your Deductible, you will still have to pay these charges:

- Copayments for Services rendered and Prescription Drugs;
- Coinsurance amounts;
- charges for Services that are not covered;
- charges that are in excess of our Allowable Charges/Covered Expenses and Maximum Benefit amounts;

- charges which exceed the Usual, Reasonable and Customary Charges (*for Out-of-Network Services*); and
- any penalties.

Out-of-Pocket Maximum

Covered Expenses are subject to an aggregate maximum per individual Insured Person as indicated in the section titled "What Your Plan Covers," as long as the Policy remains in force. The aggregate maximum includes all Maximum Benefits specified in this Policy, including those specified in What Your Plan Covers. Copayments will not apply towards your Out-of-Pocket maximum.

Provider Network – United States

This Policy was designed to help make your health care more affordable in the United States by offering you access to a robust network of medical Providers. ***It is important that you understand how the Providers you choose to use for medical care and the type of Services you receive in the United States affect how much you have to pay for medical Services***. This section explains payment rules when receiving Covered Services from different types of Providers in the United States under this Policy. This section does not include the specific Deductible amounts under your plan, if any. As you read this section, please keep in mind that you will have to check the section titled, "What Your Plan Covers" for those details.

In-Network Provider: WellAway provides access to a PPO Network (the "Network"). All Providers in the Network that are *"In-Network Providers"* are Providers available to you for your healthcare needs. ***Using an In-Network Physician and Provider will reduce your costs and allow you to obtain significant savings but are still subject to those Services that require Pre-Authorization and other requirements under this Policy. Your ID Card is your key to accessing all of the Providers available to you as an Insured Person. Contact our ConciergeCare team via the telephone number on your ID Card. We are experienced in guiding you to the most appropriate providers for you. Please present your ID Card to your Provider at the time of receiving Services***.

Out-of-Network and Non-Network Provider: ***Using an Out-of-Network or Non-Network Provider (providers who do not take any insurance plans) is more costly for you.*** We will only reimburse Out-of-Network Providers the Coinsurance amount (as stated in What Your Plan Covers) of the Usual, Reasonable and Customary Charges **(except when such Services are Medical Emergency Services).** The Out-of-Network Provider may bill you the difference between the amounts reimbursed by us and the Provider's billed charges. You will pay more than if you used an In-Network Provider. If a discount is negotiated with the Provider, the savings realized will be passed on to you. In the event that you utilize a Non-Network Provider that has chosen to "opt-out" of billing an insurance company and did not provide you with a medical claim in CMS 1500 formats, or UB04 CMS formats, your claim will be deemed a non-reimbursable claim.

Out-of-Area Provider: If there is no In-Network Provider located within a 50-mile radius of your local residence, the claim will be paid as In-Network or at the rate of a similarly situated In-Network Provider, after applicable Deductible, Coinsurance and Copayment amounts have been applied.

Can I Cancel My Policy At Any Time?

You will only be allowed to cancel your Policy and obtain a refund of your Premium if you withdraw from classes within thirty (30) days from the Effective Date of coverage under a school-approved leave of absence. You must provide written proof of the approved leave of absence and return date to your Home Country. You must provide written notification to the Insurer of your refund request within thirty (30) days of the Effective Date of coverage. You will not be eligible for a refund if there are any claims on file during the Policy Period. A Force Majeure event will not operate to automatically entitle any Insured Person to a refund of Premium previously paid and will also not operate to extend the Policy Period.

When Is My Premium Due?

Your 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.

Can My Policy Be Terminated?

Insurer reserves the right to terminate your Policy effective as of 12:01 a.m. Eastern Standard Time (EST) on such date that an Insured Person:

1. Is not eligible or no longer eligible as defined by this Policy. We reserve the right to review eligibility requirements at any time.
2. Failed to observe the terms and conditions of this Policy or failed to act with utmost good faith.
3. Failed to pay the required Premium.
4. Acts in a manner that results in added costs to the Insurer.
5. Committed an act of Fraud with respect to this Policy. Fraud means deception by a person with the intent to wrongly benefit him/her. It includes any act that is defined as fraud under applicable laws or regulations, and includes, but is not limited to:
    a. Using another person's name as your own;
    b. Using an ID Card that does not belong to you;
    c. Giving your ID card to someone else;
    d. Misuse of Services;
    e. Billing for Services that were not provided;
    f. Giving false information on your records which may be regarded as being of importance to us. This includes records that relate to your Eligibility;
    g. Making statements on the Application Form or in the course of applying for the Policy which we determine, on reasonable grounds, that you have knowingly or recklessly provided information which you know or believe to be untrue or inaccurate or failed to provide information which we have asked for;
    h. When making any claim under the Policy, knowingly or recklessly providing information which you know or believe to be untrue or inaccurate, failing to provide information which we have asked for or claiming benefits for any purpose other than as provided for under this Policy;
    i. Agreeing to any attempt by a third party action or omission to obtain an unreasonable pecuniary advantage to our detriment; or
    j. Purchasing this Policy for the purpose of cancelling it after a planned medical Service has been rendered.

General Terms and Conditions

1. The headings of sections contained in this Policy are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
2. References to "you" or "your" throughout refer to you as the Policyholder and to your Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Policyholder or solely to your Dependents will be noted as such.
3. References to "we", "us", "our", "Insurer" and "Company" throughout this Policy refer to Davies Insurance Limited on behalf of the WellAway Segregated Account. The plan is underwritten by Davies Insurance Limited on behalf of the WellAway Segregated Account and Arch Re rated "A+" (Excellent) AM Best Company and administered by PayerFusion Holdings, LLC, a licensed third party administrator in the United States.
4. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section of this Policy or within the particular section where it is used.
5. The official language governing this Policy is United States English and shall remain the ruling language on coverage, benefits and definitions. If any dispute arises as to the interpretation of this document, the English version of this document shall be deemed to be conclusive and take precedence over any other language version of this Policy.
6. The Plan Administrator, PayerFusion Holdings, LLC, is an entity designated by the Insurer for purpose of providing administrative services related to this Policy on behalf of the Company.
7. The declarations of the Policyholder and the Dependents, if any, serve as the basis for this Policy. Any references in this Policy to the Insured Persons that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.
8. Any notice required under this Policy must be in writing. Any notice given by us will be communicated to either the Policyholder or the Policyholder's agent or broker. Such notices are limited to e-mail, postal mail or via the member

portal. Any notice from the Policyholder should be sent to the Plan Administrator's office or by e-mailing: enrollment@wellaway.com.

9. In the event any clerical error or delays in keeping records by the Insurer, the Insurer:
   a. will not deny insurance which should otherwise have been granted;
   b. will not extend insurance which should otherwise have been terminated; and
   c. will be subject to proper adjustment of Premium when an adjustment is needed.
10. Benefits are paid to the extent that an Insured Person receives any of the Treatments covered under What Your Plan Covers following the Policy Effective Date, including any additional Waiting Periods and up to the date such individual no longer meets the definition of Insured Person.
11. This Policy is governed by and shall be construed in accordance with the laws of Bermuda and shall be subject to its exclusive jurisdiction.
12. All disputes arising out of or relating to this Policy, or any matter that is related directly or indirectly to this insurance, which cannot first be resolved by the parties through settlement negotiations for a period of sixty (60) days, shall be resolved exclusively through binding, non-appealable and confidential private arbitration. The arbitration and such proceedings shall be administered based on the arbitration laws of Bermuda. Notice requesting arbitration must be in writing and sent certified or registered mail, return receipt requested. Each party shall choose one arbitrator and the two arbitrators shall choose an impartial third arbitrator who shall preside over the arbitration proceeding. If either party fails to appoint its arbitrator within thirty (30) days after being requested to do so by the other party, the latter, after ten (10) days' notice by certified mail or registered mail of its intentions to do so, may appoint a second arbitrator. Within thirty (30) days after notice of appointment of all arbitrators, the panel shall meet and determine the timely period for briefs, discovery Procedures and schedule for hearings. The panel shall be relieved of all judicial formality and shall not be bound by the strict rules of Procedure and evidence. The decision of any two arbitrators when rendered in writing shall be final and binding. The panel is empowered to grant interim relief as it may deem appropriate. The place of any arbitration hearing shall be Bermuda. The panel shall interpret this Policy as an honorable engagement rather than as merely a legal obligation and shall make its decision considering the custom and practice of the applicable insurance business as promptly as possible following the termination of the hearings.
13. All legal actions arising from this Policy shall be barred one hundred eighty (180) days from the event that gave rise thereto.
14. The Insurer's liability under this Policy will be conditioned upon each Insured Person complying with its terms and conditions.
15. The Policyholder must inform the Insurer within thirty (30) days of any changes related to Insured Persons (i.e., change of address, visa status or marital status) or of any other material changes that affect information given in connection with the Application Form under this Policy.
16. The confidentiality of your information is of paramount concern to Insurer. Insurer complies with data protection legislation and medical confidentiality guidelines. Information submitted to Insurer over our website is normally unprotected until it reaches us. We do share information, but only as it pertains to the administration of your health care benefits. We may also disclose information when the law requires or permits us to do so.
17. Waiver by the Insurer of any term or condition of this Policy will not prevent us from relying on such term or condition thereafter. If we choose to waive our rights under this Policy regarding a specific term or provision, it shall not be interpreted as a waiver of our right to administer or enforce this Policy in strict accordance with its terms and conditions. In the event the Insured Person terminates this Policy prior to the expiration of the current Policy Period for any reason whatsoever, Insured Person waives all rights to enforce any specific term or provision of the Policy.
18. If the Policyholder dies, this Policy will automatically be terminated. Dependent(s), if any, will no longer be eligible for coverage under this Policy and have no transfer or continuation rights or privileges with Insurer. Upon death of the Policyholder, the Insurer must be notified within ten (10) days. A death certificate must be provided to Insurer.
19. The Insurer is not responsible for the quality of care received from any institution or individual. This Policy does not give the Insured Person any claim, right or cause of action against Insurer based on an act of omission or commission of a Hospital, Provider, Physician or other provider of care or Service.
20. This Policy does not meet the United States requirements to qualify as "minimum essential coverage" for health insurance under the Affordable Care Act. As such, this Policy does not include all essential health benefits as required by the Affordable Care Act and is not subject to, and is not administered as, a PPACA (Patient Protection and Affordable Care Act).
21. This short-term Policy is not subject to guaranteed issuance or renewal and may only be rewritten for new and completely separate Policy Periods (as long as you meet the Eligibility requirements). Coverage does not continue from one policy to another. This means that a new Application Form must be submitted, a new Effective Date is given, and a new Deductible and Out-of-Pocket expenses must be met.

22. Any Services, Procedures or Treatments, to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States including, but not limited to, any Services, Procedures or Treatments provided in the Restricted Areas will not be covered.

Definitions

Accident – means an unforeseen, unexpected, and unintentional event due exclusively to an external cause of a violent nature beyond the control of the Insured Person, resulting, directly and independently of all other causes, in bodily trauma to the Insured Person and which occurs after the Policy Effective Date.

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

Acute – means Medically Necessary medical condition, which is brief, has a definite end point and which we, on medical Advice, determine responds to and can be cured by Treatment.

Admission – means the period from the time that an Insured Person enters a Hospital, or other approved health care Facility as an Inpatient until discharge.

Advice – means any consultation by a Physician or Specialist including the issue of drugs and Dressings or repeat Prescription Medications or Drugs.

AIDS - means medical Services and costs provided to the Insured Person as a consequence of Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and or related to the virus HIV positive.

Air Ambulance – means an aircraft specially equipped with the necessary medical personnel, Supplies and Hospital equipment to treat life-threatening Illnesses and/or Injuries for persons whose conditions cannot be treated locally and must be transported by air to the nearest Facility that can adequately treat their conditions.

Allowable Charges – means the maximum dollar amount that we will reimburse a Provider for a specific Service.

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

Application Form – means the form, either written or electronic, that was completed and signed by the Insured Person to request insurance coverage under this Policy. It includes any medical history, questionnaires, and other documents requested by us prior to the issue of insurance coverage.

Attention Deficit Disorder (ADD) – means a biologically based condition causing a persistent pattern of difficulties resulting in one or more of the following behaviors: inattention; hyperactivity; impulsivity.

Attention Deficit Hyperactivity Disorder (ADHD) – means a problem with inattentiveness, over-activity, impulsivity, or some combination of these. For these problems to be diagnosed as ADHD, they must be out of the normal range for the child's age and development.

Bodily Injury – means an Injury, which is caused solely by an Accident, which results in the Insured Person's dismemberment, disablement or other physical external Injury.

Cesarean Section – means the delivery of the fetus through an abdominal incision in conditions where the vaginal route is contraindicated.

Cancer – means the general term used for all malignant disorders caused by the uncontrolled multiplication of mutated cells (new growths or tumors). These cells can destroy the surrounding tissue and produce metastases (secondary growths).

Chiropractic Services – means a system of Diagnosis and Treatment based on the idea that the nervous system co-ordinates all of the body's functions, and that disease results from a lack of normal nerve function. Chiropractic Services does not include Prescription Medication, Drugs or Surgery.

Chiropractor – means any person who is legally licensed to practice Chiropractic Services in the country where Treatment is provided. A chiropractor uses manipulation to change body structures, such as the spinal column, to relieve pressure on nerves coming from the spinal cord caused by a vertebrae being displaced.

Chronic Condition – means an Illness, Injury, impairment or physical or mental condition that involves Inpatient care or continuing Treatment by a health care Provider, such as Cancer, etc.

Club Sports - means any sports offered at a university or college in the United States that compete with other universities, or colleges, but are not regulated by the National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA), and do not have varsity status.

Coinsurance – means the percentage of our Allowed Charges that you must pay before we will pay our portion of the Allowable Charges for Covered Services. The Coinsurance percentage is calculated after all other Cost Share amounts for a given Service, such as your Deductible and/or Copayment.

Complications of Pregnancy – means: (a) when pregnancy is not terminated, conditions that require Hospital Confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, including but not limited to: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and (b) when pregnancy is terminated; (1) non-Elective Cesarean Section; (2) ectopic pregnancy that is terminated; or (3) spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy will not include false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; mild hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct Complication of Pregnancy.

Confinement – means an Inpatient stay at an approved Extended Care Facility for necessary skilled Treatment or Rehabilitation in accordance with this Policy.

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

Copayment – means a fixed dollar amount you must pay when you receive certain Covered Services. It must be paid before any benefit is payable by us.

Cost Share - means your share (Deductible, Coinsurance and Copayments) of the cost for specific Covered Services under the plan selected.

Covered Expenses – means the Usual, Reasonable and Customary Charges Incurred by an Insured Person, while covered under this Policy, for Medically Necessary Services, Treatments or Supplies described under the section titled *What Your Plan Covers*.

Covered Services - means those Services which meet the criteria listed in the *What Your Plan Covers* section of this Policy.

Critical Condition – means an immediate life threatening or perilous Illness or conditions due to an Accident or natural causes, which requires urgent specialized Treatment without delay.

Custodial Care – means (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or Surgical Treatment will enable him to live outside an institution; and (3) rest cures, Respite Care and home care provided by Family Members. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a Service or Treatment is Custodial Care.

Deductible – means the first part of the Allowable Charges you pay for Covered Services per Policy Period before your plan starts to pay as listed in What Your Plan Covers. *Note*: Copayments and your cost of Prescription Medication/Drugs will not count towards the individual or Family Deductible. Not all plans include a Deductible.

Dentist or Dental Surgeon – means is a health care Provider who specializes in the Diagnosis, prevention and Treatment of diseases and conditions of the oral cavity.

Dependent – means a member of the Policyholder's family (Family Member) who is enrolled under this Policy after meeting all of the Eligibility requirements and for whom Premiums have been received by the Insurer.

Diagnosis – means the determination by a Physician or Specialist of the nature of a disease or condition made from a study of the signs and Symptoms of a disease or condition.

Dialysis – means the provision of an artificial replacement for lost kidney function (renal replacement therapy) due to acute kidney failure. Dialysis may be used for sudden but temporary loss of kidney function (acute renal failure). Dialysis is done in Dialysis units which are part of Hospitals and clinics or at home.

Domestic Partner means a person of the same or opposite gender with whom the Policyholder has established a Domestic or Registered Partnership.

Domestic or Registered Partnership means a relationship between the Policyholder and one other person of the same or opposite gender who meet at a minimum, the following eligibility requirements:

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the venue in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. the Policyholder has submitted to us acceptable proof of evidence of common residence and joint financial responsibility, and certificate of registered partnership (if applicable); and
5. the Policyholder has completed and submitted any required forms to us and we have determined the Domestic Partnership eligibility requirements have been met.

Dressings - means materials used for Dressing wounds.

Durable Medical Equipment (DME) – means equipment prescribed by Physician designated for repeat and prolonged use and which is Medically Necessary to improve the functioning of a malformation of the body, Treatment of an Illness, or to prevent further deterioration of the Insured Person's medical conditions. Please refer to DME category under the *What Your Plan Covers* section of this Policy for more details.

Elective – means any care, Service, Procedure, or Surgery performed at the choice of the patient, for which there is no Medical Necessity, and/or which does not treat an Accident, Illness, or Injury (such as care provided primarily as a convenience or to improve or preserve appearance, self-esteem or future possible effects on health, posture or body function).

Eligibility – means the requirements that an Insured Person, including the Policyholder and/or his/her Dependents must meet at all times in order to be covered under this Policy.

Emergency - means a sudden onset of a medical condition with acute Symptoms of sufficient severity that in the absence of immediate medical attention (or as soon thereafter as care can be made available, but in any case not any later than forty-eight (48) hours after the onset) and in the absence of which care an Insured Person could reasonably result in:

- permanently placing the Insured Person's health in jeopardy;
- causing other serious medical consequences;
- causing serious impairment to bodily functions;
- causing serious and permanent dysfunction of any bodily Organ or part;
- causing loss of life or limb; or
- causing death.

Emergency Dental Treatment – means acute Emergency dental Treatment due to a serious Accident requiring hospitalization. The Treatment must be received within 72 hours of the Emergency event.

Emergency Medical Transportation – means that in the event of a life threatening Emergency, when appropriate Treatment is not available locally, this Policy provides Emergency Medical Transportation to the closest medical Facility capable of providing the required care.

Estimate – means the assumed cost for the Services or Procedures to be conducted either by a Physician or laboratory for the patient for a given Diagnosis or as part of an investigation in order to obtain a Diagnosis.

Evacuation – means costs Incurred in moving an Insured Person from the place of incident to the nearest appropriate medical Facility, as determined by the attending Physician in conjunction with our medical advisors.

Evidence Based Medicine – means the use of established medical guidelines and relevant information from peer-reviewed medical research to address a specific clinical issue, evaluating the risks and benefits of diagnostic tests, procedures and therapeutic measures. It is the application of simple rules of science and common sense to determine the best medical decision for the patient.

Exclusion – means specific provision excluding coverage for conditions or Illnesses for this Policy. Exclusions are imposed when the Policy is issued as a condition for the issuance of coverage. Exclusion or Exclusions, if issued as a condition for the issue of coverage, form a part of this Policy through an endorsement or rider or as listed in the Exclusions and Limitations section of the Policy.

Experimental and/or Investigational – means any Treatment, Procedure, technology, Facility, equipment, Drug, Drug usage, device, or Supplies not recognized as accepted medical practice in the United States or by Insurer that fails to meet the following criteria:

1. Controlled studies published in peer review medical literature demonstrate that such Service or Supply has a net beneficial effect on health outcomes for a specific Diagnosis; or under study, investigation, trial period or is limited to research; or
2. Such Service or Supply is in accordance with generally accepted standards of medical practice in the United States; or
3. At the time such Service or Supply is received by an Insured Person, it has been approved for the particular indication or application in question by the United States Food and Drug Administration (FDA) or other federal or state governmental agency whose approval is required in the United States, regardless of where the medical expenses are Incurred.

Extended Care Facility – means a nursing and/or Rehabilitation center approved by Insurer that provides skilled and Rehabilitation Services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest homes, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

Facility – means any location where Services Supplies or Drugs are provided, including, but not limited to, an Ambulatory Surgical Center or Hospital.

Family - means the Policyholder and a Family Member.

Family Member – means a spouse, domestic partner, father, mother, brother, sister, or child of the Policyholder.

Food and Drug Administration (FDA) – means an agency of the United States Health and Human Services, one of the United States federal executive departments. The FDA is responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over- the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics and veterinary products.

Force Majeure – means an act of God, fire, earthquake, flood, explosion, war, invasion, insurrection, riot, mob violence, governmental actions or shutdowns, civil disturbances, pandemics, epidemic, quarantines, health crisis, viral outbreaks (including, without limitation, the coronavirus referred to as COVID-19, sabotage, inability to procure or a general shortage of labor, equipment, facilities, materials or supplies in the open market, failure or unavailability of transportation, strike, lockout, action of labor unions, a taking by eminent domain, requisition, laws, orders of government or of civil, military or naval authorities, or any other cause, whether similar or dissimilar to the foregoing not within the reasonable control of Insurer.

Hereditary - means transmitted from parents to offspring; inherited.

Home Country - means the country where an Insured Person has his or her true, fixed and permanent home and principal establishment.

Host Country - means (1) the country where the Insured Person resides the majority of any calendar or Policy Period; or (2) the country where the Insured Person has resided more than one hundred and eighty (180) continuous days during any three hundred and sixty-five (365) day period while the Policy is in force.

Hospital – means and includes only Acute Care Facilities licensed or approved by the appropriate regulatory agency as a hospital, and whose Services are under the supervision of, or rendered by a staff of Physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional Nurses. The Hospital does not include convalescent and nursing homes, rest homes, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

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

Home Health Care Plan – means a program: a) for the care and Treatment of an Insured Person in his home; b) established and approved in writing by his attending Physician; and c) Certified, by the attending Physician, as required for the proper Treatment of the Injury or illness, in place of Inpatient Treatment in a Hospital or in an Extended Care Facility.

Hospice or Terminal Care - means an agency which provides a coordinated plan of home and Inpatient care to a terminally ill person for whom curative Treatment is no longer available and which meets all of the following tests: a) has obtained any required state or governmental license or certificate of need; b) provides services 24-hours-a- day, 7 days a week; c) is under the direct supervision of a Physician; d) has a Nurse coordinator who is a registered Nurse or a licensed practical Nurse; e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice Services; g) has a full-time administrator; and h) maintains written records of Services provided to the patient.

Hospital Intensive Care Unit – means a section, ward or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing twenty four (24) hour professional medical Treatment for critically ill patients and is equipped with Supplies and equipment for such medical Treatment.

Hospital Room and Board – means a private or semi-private Hospital room as specifically approved by our Plan Administrator.

Human Immunodeficiency Virus (HIV) – means all diseases caused by and/or related to the HIV Virus. (Refer to AIDS definition)

Identification Card (I.D. card) – means the cards we issue to Policyholders. The cards are our property, and are not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Policy.

Illness – means a physical sickness, disease, Complications of Pregnancy of an Insured Person. This does not include mental illness.

Incurred – means the date an Infectious Disease, Illness or Injury occurred and the Insured Person receives the Service or Supply for which the charge is made.

Infectious Disease – means a common communicable disease caused by viruses, bacterial fungi or parasites and presence of a microbial agent.

Injury – means a Bodily Injury that is: 1) sustained by an Insured Person while covered under this Policy; and 2) caused by an Accident externally, directly and independently of all other causes. An Insured Person must begin receiving Services, Supplies or Treatment within 72 hours from the time of Accident in order for it to be considered an Injury. All Injuries sustained by one person in any one Accident including all related conditions and recurrent Symptoms of these Injuries, are considered a single Injury.

In-Network Provider – means any health care Provider, including an In-Network Physician, who, at the time Covered Services are rendered to you, has agreed to accept a negotiated discount for Services.

Inpatient – means a person admitted to an approved Hospital or other health care Facility for a Medically Necessary overnight stay in excess of 24 hours.

Insured Person – means the Policyholder or his/her Dependents enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.

Intercollegiate Sport – means a sport that: (i) has been accorded varsity status by the participating university or college; (ii) is administered by such university's or college's department of intercollegiate athletics for which the eligibility of the participating student athlete is reviewed and certified in accordance with the applicable intercollegiate sports organization's legislation, rules or regulations; (iii) entitles qualified participants to receive the participating university's or college's official awards; and (iv) includes travel, only within the contiguous United States, including Alaska and Hawaii and only directly and without interruption between home, the university/college and the premises of the Intercollegiate Sporting event.

Interscholastic Sport – means a sport played between secondary schools.

Intramural Sport- means a sport that: (i) is approved by the sports director or athletic director of the university or college; and (ii) involves only students at the same college or university; and (ii) takes place within the walls, boundaries and grounds of said university or college.

Look-back Period - means the amount of time that will be reviewed to determine if a claim is related to a Pre-Existing condition.

Loss (for the Accidental Death and Dismemberment benefit) - means with regard to hands and feet, actual severance through and above the wrist or ankle joints; with regard to eyes, entire irrecoverable loss of sight. Loss in reference to other coverages means Injury or damage sustained by Policyholder as a consequence of the happening of one or more of the Accidents against which the Insurer has undertaken to indemnify the Policyholder.

Maintenance – means continuation of care and management of the patient when the therapeutic goals of a Treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value.

Maternity Care – means the cost of prenatal care, delivery charges for mother and baby, Medically Necessary Cesarean Sections, and postnatal Treatment subject to the specific limit.

Maximum Benefit – means the payment specified in What Your Plan Covers, for specific Services, which is the maximum amount payable by Insurer per person, per Policy Period (unless otherwise noted) regardless of the actual or Allowable Charges. This is after the Insured Person has met his/her Cost Share amounts.

Medical Emergency Services – means the initial Treatment for an Emergency.

Medically Necessary/Medical Necessity – means those Services or Supplies that which are provided by a Hospital, Physician or other approved medical Providers and are defined from a medical point of view as appropriate and necessary. They must:

1. Be necessary to define or treat the condition, the Illness or the Injury of the patient;
2. Be appropriate to the Symptoms, Diagnosis or Treatment of the patient;
3. Comply with the medical practices generally accepted and with the professional medical standards applied by the medical community at the same time the patient receives the relevant care;
4. Be required for other reasons than comfort or pleasure of the patient or his/her Physician;
5. Not solely for the Insured Person's convenience, the Physician's convenience or any other Provider's convenience;
6. Have medical proven and demonstrated effects;
7. Be considered as from the most appropriate type and level;
8. Be provided with an equipment, in quantity and quality appropriate to the level of care required by the patient condition;
9. Be only provided during the period appropriate to the patient condition;
10. When applied to an Inpatient, it further means that the medical Symptoms or condition require that the Services or Supplies cannot be safely provided as an Outpatient;
11. Is not a part of or associated with the scholastic education or vocational training of the patient; and
12. Is not Experimental or Investigative.

The Insurer retains the right to determine the Medical Necessity of a planned Treatment. The appropriateness of care and the Treatment plan will be reviewed in consultation with the attending Physician and alternative care options may be recommended.

Medication Guide - means the guide then in effect issued by us where you may find information about Prescription Drugs that require prior coverage authorization and Self- Administered Prescription Drugs that may be covered under your plan. Note: The Medication Guide is subject to change at any time. Please visit www.wellaway.com for the most current guide or you may call the ConciergeCare Counselor phone number on your Identification Card.

Network – means a network of participating medical providers such as hospitals and doctors where you pay less if you use providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Non-Network Provider – means a Provider who does not take any insurance plans and has chosen to "opt-out" of billing an insurance company.

Notification – means an act of notifying, making known or giving notice of upcoming or planned Treatment by means of written notice or verbal request. Notification does not constitute approval by the Insurer.

Nurse – means a person licensed as a registered Nurse or licensed practical Nurse by the appropriate licensing authority in the areas which he or she practices nursing.

Nursing Services – means home nursing care (only payable if prescribed by attending Physician and approved by us). The service must immediately start after the patient is discharged from the Hospital. Nursing Services related to aid in the Activities of Daily Living are not covered by this Policy.

Oncology – means Specialist fees, diagnostic tests, and radiotherapy, chemotherapy and Hospital charges Incurred in relation to the planning and carrying out Treatment for Cancer, from the point of Diagnosis.

Organ – means a part of the human body that performs a specific vital function (heart, lung, kidney, pancreas, liver, bone marrow).

Organ Transplant/Transplant – means the Surgical Procedure of one or more Organs moved from a donor (living or deceased), to an Insured Person as the recipient or; tissue Surgically moved to an Insured Person from a donor (living or deceased) or the same Insured Person.

Osteopath – means a licensed person or professional who practices osteopathic medicine, which consists of overall health and the interconnected relation among the body's nerves, muscles, bones, and organs.

Other Insurance Plan – means a plan (other than this Policy) that provides insurance, Reimbursement or service benefits for Hospital, Surgical or other medical expenses.

Out-of-Network Provider – means a Provider who, at the time Services are rendered to you, does not contract with your health insurance plan or your provider network and has not agreed to accept a negotiated discount for Services.

Out-of-Pocket – means your expenses for Services that are not reimbursed by us. Deductible and Copayments (including Prescription Medication) do not apply towards the Out-of-Pocket Maximum.

Outpatient – means Services, Supplies or equipment received while not an Inpatient in a Hospital, or other health care Facility, or overnight stay.

Outpatient Services – means Medically Necessary Services provided to an Insured Person, who is not a registered Inpatient in a Hospital, to prevent and treat Injuries or Illnesses. Outpatient Services shall include, but are not limited to:

1. Comprehensive diagnostic and evaluation Services;
2. Outpatient care and Treatment, pre-care, aftercare, Emergency care, Rehabilitation and supportive transitional Services; and
3. Professional consultation.

Palliative Care – means Inpatient, day-care or Outpatient Treatment following the Diagnosis that the condition is terminal and Treatment can no longer be expected to cure the condition.

Pharmacy Benefit Manager (PBM) – means, in the United States, an entity that is primarily responsible for processing and paying prescription drug claims. It is also responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

Physician – means any person who is duly licensed and meets all of the laws, regulations, and requirements of the jurisdiction in which he/she practices medicine, who is acting within the scope of that license or certification; Physician (M.D. or D.O.), a Dentist (D.D.S. or D.M.D.), a Nurse Midwife or any other non-physician and non-dentist practitioner for whose Services benefits are provided under this Policy. This term does not include; (1) an intern; or (2) a person in training.

Plan Administrator - means the third party administrator administering this Policy's terms and conditions on behalf of the Insurer.

Podiatric Care – means a medical specialty concerned with the care and Treatment of the feet.

Policy – means the agreement between Insurer and the Policyholder. The Policy includes this document, the Policy Declarations, any Application Forms, any medical questionnaires, the last issued Identification Card, and any amendments or endorsement modifications made in accordance with the Policy. This also includes any riders or endorsements purchased by the Policyholder.

Policy Effective Date – means the date that this Policy first takes effect.

Policyholder – means a person that has applied for coverage and is named as the Policyholder in this Policy.

Policy Period – means the period that begins on the effective date of this Policy and ends on the termination date as indicated in the Certificate of Coverage.

Policy Period Maximum – means the maximum which will be paid for all benefits in total for each Insured Person, each Policy Period.

Pre-Authorization – means a process by which an Insured Person obtains written approval for certain medical Procedures or Treatments, prior to the commencement of the proposed medical Treatment or Procedure. Certain medical Procedures will require the Pre-Authorization process to be followed in order for the Service to be covered and to maximize the benefits of the Insured Person.

Pre-Existing Condition – means any Illness or Injury, physical or mental condition during the Look-back Period for which an Insured Person:

(i) received any Diagnosis, medical Advice or Treatment prior to the Policy Effective Date; or
(ii) had taken any Prescription Medication or Drug prior to the Policy Effective Date; or
(iii) where distinct signs or Symptoms were evident prior to the Policy Effective Date; or
(iv) based upon reasonable medical certainty the Illness, Injury, physical or mental condition existed prior to the Policy Effective Date.

Premium(s) – means the consideration owed by the Policyholder to the Insurer in order to secure benefits for its Insured Persons under this Policy.

Premium Payment Date – means the recurring date specified in the Policy upon which the Premium for this Policy is due.

Prescription Drugs/Medication – means medications which are prescribed by a Physician and which would not be available without such prescription and approved by the FDA in the United States or other applicable administrative organizations in the Host Country and cannot be obtained Over-the-Counter at a pharmacy. Certain Treatments and medications, such as vitamins, herbs, aspirin, cold remedies, medicines, Experimental or Investigative drugs, or medical Supplies even when recommended by a Physician, do not qualify as Prescription Drugs.

Prescription Drug Formulary – means a schedule of Prescription Drugs approved for use which will be covered, if not otherwise excluded by this Policy and dispensed through participating pharmacies.

Prescription Supply – means certain Supplies approved for use which will be covered, if not otherwise excluded by this Policy, and dispensed through participating pharmacies, including, but not limited to, diabetic meters, test strips and lancets.

Primary Care - means the first contact by a Physician for an Insured Person with an undiagnosed health concern of varied medical conditions, not limited by cause, organ system, or diagnosis not previously present.

Procedure – means a practice, a series of steps, or Treatment to follow after a given Diagnosis is obtained.

Professional Sports – means activities in which the participants receive payment for participation. This does not include participants in National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA).

Provider – means any location where Services, Supplies or Drugs are provided, including, but not limited to, an Ambulatory Surgical Center or Hospital.

Psychiatric – means a health condition that changes a person's thinking, feelings, or behavior (or all three) and that causes the person distress and difficulty in functioning. As with many diseases, mental illness is severe in some cases and mild in others. Inpatient mental health, as indicated in the Policy, may be approved by us for severe psychotic or neurotic episodes where Treatment cannot be given on an Outpatient basis for risk of injury to self or others.

Psychiatric Physician – means a Physician who specializes in psychiatry or has the training or experience to do the required evaluation and Treatment of mental conditions.

Rate - means the amount we charge for coverage.

Reconstructive Surgery – means the use of Surgery that takes place due to a covered Surgical Procedure or Accident, and is Medically Necessary in order to maintain or restore normal bodily function.

Rehabilitation - means Therapeutic Services designed to improve a patient's medical condition within a predetermined time period through establishing a Maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery. Inpatient Rehabilitation is only covered during the acute and sub-acute recovery phase of Treatment and only when authorized by the Insurer's Plans Administrator.

Reimbursement – means the amount of money refunded to the Policyholder for Usual Customary and Reasonable Covered Expenses, as indicated in this Policy.

Renal Failure - means the acute, sudden and often temporary loss of kidney function.

Rescission or Rescind - means action to retroactively cancel or discontinue coverage under this Policy. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premium.

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

Restricted Area – means any Country, Provider, Facility or individual, to the extent that the provision of coverage, payment of a claim or the provision of benefits would expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States.

Right to Recovery – means that it allows the Insurer to have a lien against the proceeds of any recovery made from a responsible third party. The right of recovery is usually enforced through direct dealings with the Insured Person who repays the Insurer after he/she has made a recovery from the responsible third party. Under the Right of Recovery, an Insurer may not take direct legal action against a wrongdoer; whereas, under Subrogation, the Insurer could take direct action. (See Subrogation section)

Self-Administered Prescription Drug – means an FDA approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Second Surgical or Medical Opinion – means the medical Advice given by a second independent Physician not involved in the Treatment, normally to get a second opinion if potentially fatal Illnesses or serious permanent disabilities are involved. This requires Pre-Authorization by the Plan Administrator.

Service(s) means evaluations, Treatments, therapies, devices, Procedures, techniques, equipment, Supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of, a licensed Physician or Provider.

Sound Natural Tooth – means a healthy unrepaired tooth or a tooth of which a major portion remains after restorative work. A Sound Natural Tooth is not carious, abscessed or defective. It does not include artificial items such as crowns or caps, braces or bands, jackets, inlays, bridges or dentures, which were installed before the date of the Injury. Repair or replacement of these items is not covered under this Policy.

Specialist – means a medical Physician whose practice is focused on a particular branch of medicine or Surgery (e.g., cardiologist).

Specialty Drug – means an FDA approved Prescription Drug that has been designated solely by us as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or a Self-Administered Prescription Drug.

Subrogation – means the substitution of one person in the place of another relative to a lawful claim or right. In a health plan this type of provision allows the plan to be substituted for the Insured Person in a case where the Insured Person takes

legal action. Theoretically, a Subrogation provision permits the Insurer to take direct legal action against a responsible third party and, therefore, the Insurer could force the Insured Person to pursue legal remedies, although he/she may not have intended to do so.

Supply – means items deemed necessary for the Treatment of an Illness or Injury.

Surgery/Surgical – means the performance of generally accepted operative and cutting Procedures including specialized instrumentations, and other invasive Procedures.

Symptoms – means a sensation or feeling that the Insured Person may experience and consider not to be normal. Such feeling or sensation may be in the form of pain or change of bodily fluids. This Symptom will not be considered an Illness or a medical condition until a licensed Physician or Specialist gives a Diagnosis.

Terrorist Acts – means an act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist Acts can include, but not be limited to, the actual use of force or violence and/ or the threat of such use. Furthermore, the perpetrators of Terrorist Acts can either be acting alone, or on behalf of, or in connection with any organization(s) or government(s).

Therapeutic Services/Outpatient Rehabilitation – means physical therapy, occupational therapy, speech therapy or oculomotor therapy.

Treatment – means medical care given to a patient for an Illness or Injury.

Usual, Reasonable and Customary Charge – Usual, Reasonable and Customary Charge (URC) means reasonable medical expenses commonly charged in the applicable country for the specific Treatment received, in accordance with standard medical and generally accepted procedures in such country. We will pay for such Treatment costs in line with the appropriate fees in the location of Treatment and according to established clinical and medical practice. This is the limit on the amount we will pay and is also known as usual, customary and reasonable; customary and reasonable; reasonable or prevailing charge. URC is for Treatment and Services related to the benefits shown in the section titled “What Your Plan Covers.” URC is derived from information compiled in a nationally-recognized database (for the service or supply in the geographic area where it is received) and fairly and accurately reflects the market rate; or the median amount negotiated with Participating Providers for the same services; or a percentage of a fee schedule developed by the Insurer that is based upon a methodology similar to a methodology utilized by Medicare (in the USA), or the applicable national social security fee schedules to determine the allowable fee for the same or similar service within the geographic market. Your Provider should advise you of the costs of the recommended Treatment or Procedure. If the costs of the Treatment or Procedure are likely to exceed Usual, Reasonable and Customary Charges, you should request a written estimate and contact WellAway before any Treatment or Procedure takes place.

Waiting Period – means the period of time beginning with the Policy Effective Date, during which limited or no benefits are available for particular Services, including, but not limited to Pre-Existing Condition(s), if applicable. After satisfaction of the Waiting Period, benefits for those Services may become available in accordance with this Policy.

How Do I Make a Claim?

What We Pay

You will be reimbursed for the Allowable Charges for Covered Services up to the Maximum Benefit amounts described in What Your Plan Covers. If you have Other Insurance, please refer to the *Coordination of Benefits* clause below.

What to Do if You Have a Claim

In order to receive reimbursement under this Policy, you must submit to us a completed claim form and the supporting documents within **one hundred eighty (180) days** from the date of Service. Claims which are not submitted within 180 days from the date the Service was rendered will not be covered. The claim form is available on your member portal at www.wellaway.com or you may request the claim form by contacting a ConciergeCare Counselor at +1.855.773.7810 or e-mail: Conciergecare@payerfusion.com.

Please send us the following information with your completed claim form:

1. Claimant's name;
2. Physician's specialty;
3. Detailed description of Service rendered (office visits, Surgery, etc.);
4. Original itemized invoices with fees on Physician/Hospital letterhead. Invoice must include patient's full name, date of birth, Diagnosis (type of Illness), date of the visit, Treatment type, Physician's charges and acceptable proof of payment (credit card receipt);
5. In the case of hospitalization, you must attach the Hospital medical notes or reports, and our Pre- Authorization provided to you. Please ensure that your invoice details the cost of private or semi-private room; and
6. Type of Currency

Charges for which we are unable to determine liability because the Insured Person failed, within ninety (90) days, or as soon as reasonably possible to: a) authorize us to receive all the medical records and information we request; or b) provide us with information we requested regarding the circumstances of the claim or Other Insurance Plan will not be covered.

To receive reimbursement for a Prescription Drug, you will be required to provide the following:

1. Completed claim form;
2. Copy of Physician's prescription;
3. Prescription Drug invoice; and
4. Proof of payment.

Prescription medications must clearly provide the name of the patient, the price of the Drug, and prescription quantity.

You may submit your claim via e-mail to conciergecare@payerfusion.com, courier, or by postal service. Mail your completed claim documents to:

PayerFusion Holdings, LLC
2100 Ponce de Leon Boulevard
Mezzanine Level – Suite 200
Coral Gables, FL 33134

Note: We encourage you to keep copies of the invoices for your records. Copies of claims are accepted as long as the integrity of the document is not altered. However, we reserve the right to request original documents at our discretion. We will notify you, in writing, if the claim is denied or if additional information is necessary for the review and/or payment of the claim within the terms of this Policy. The claim will be paid at the exchange rate based on date of service.

Services in the United States

In the United States, the Hospital or Provider may submit the claim directly to us and we will pay any Covered Expenses directly to the Provider or Hospital. You must present all health care Providers with a copy of your Identification Card. Your Provider will then contact us to verify Eligibility and the coverage provided under this Policy. You will only be responsible for: (i) expenses that

are not covered by this Policy; (ii) any Deductible; (iii) any amounts in excess of Usual, Reasonable and Customary Charges; and (iv) any amounts in excess of the Maximum Benefit.

Note:

1. Your Providers must submit claims to us within **one hundred eighty (180) days** from the date of Service. No benefits will be paid for claims exceeding this time period.
2. Medical claims submitted by Providers within the United States must be in CMS 1500 formats, or UB04 CMS formats. If you have already paid the Provider, you must submit your reimbursement pursuant to the guidelines set forth above. We will reimburse you in accordance with the terms of the Provider contract, if one exists.
3. In the event that you utilize a Non-Network Provider that has chosen to "opt-out" of billing an insurance company and did not provide you with a medical claim in CMS 1500 formats, or UB04 CMS formats, your claim will be deemed a non-reimbursable claim.

Claims Payment

Whenever possible, we will settle the expenses directly with the Providers for Services rendered. When not possible, we will reimburse the Policyholder in accordance with the terms and conditions of this Policy. In the event the Policyholder is deceased, the Plan Administrator will pay any unpaid benefits to the spouse as named in the Application Form. If no spouse is named, any unpaid benefits will be paid to the deceased primary Insured Person's estate. In the event of a divorce, all payments are payable to the Policyholder unless a divorce decree or court order indicates otherwise.

Fraudulent/Unfounded Claims

If any claims presented under this Policy are in any respect fraudulent or unfounded, or if any fraudulent means or devices are used by the Insured Person or anyone acting on the Insured Person's behalf, such as misrepresentation on the Application Form, omissions of information or any attempts, through deceit, to obtain benefits for any person that otherwise would not be provided or payable, we will deny all benefits paid and/or payable in relation to that claim and all Premiums previously paid shall be forfeited and, if appropriate, recoverable. We will terminate the Policy as of the Policy Effective Date. We reserve the right to take legal action in order to seek compensation for any damage caused to us. You will be required to pay back any benefits that were unduly paid to you under this Policy.

Refusal to Accept Assignment

Insurer reserves the right to make payment directly to the Insured Person and to refuse to honor an assignment of any claim to any person or party.

Release of Medical Records

By applying for coverage, the Insured Person agrees on behalf of him/herself and his Dependent(s), to let any Physician, Hospital, pharmacy or Provider give us all medical information determined by us to be necessary, including a complete medical history and/or Diagnosis in order to validate a claim. We will keep the information confidential. Furthermore, by applying for coverage, the Insured Person authorizes the Insurer to furnish any and all records pertaining to such Insured Person, including complete Diagnosis and medical information, to an appropriate medical review board, utilization review board or organization and/or to any administrator or other insurance carrier for purposes of administration of this Policy. There may also be additional health information requests from the Insurer. The Plan Administrator will attempt to retrieve the medical records on behalf of the Insured Person; however, if these are not provided to us, it will be the responsibility of the Insured Person to provide the information in order to validate the claim. The claim will be closed with non-payment until the required information is provided to us. Expenses Incurred for such records will be at the sole expense of the Insured Person. The Insured Person has ninety (90) days from date he/she received Notification in writing requesting additional information to authenticate and validate a claim. If the information is not provided to the Plan Administrator within the allotted timeframe, the claim will be denied.

Request for Reproduction of Records

Medical information such as claims, invoices, explanation of benefits, and Pre-Authorizations are available free of charge by logging into your member portal at www.wellaway.com. Reproductions of claims or records requested by the Insured Person or his/her representative to the Insurer will have a fee payable prior to such being provided.

Overpayments

We may recover benefit payments made erroneously and may supply subsequent benefits otherwise payable to offset any overpayment. We reserve the right to deduct overpayments made in error to a Provider on behalf of an Insured Person from a Reimbursement claim. Deduction of an overpayment to an Insured Person will be properly documented on the explanation of benefits.

Right of Examination and Autopsy

The Insurer and the Plan Administrator reserve the right, through our medical representatives, to examine any Insured Person whenever and as often as we may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, as well as requested health information questionnaires, and where required, shall sign all authorization forms necessary to give us a full and complete medical history. In the event of death, the Insurer and the Plan Administrator reserve the right to require an autopsy for the processing of a claim under this Policy. Failure to comply with this clause will result in the automatic denial of all related claims.

Coordination of Benefits

When an Insured Person has coverage under an Other Insurance Plan, including, but not limited to, government programs, health insurance in your Host Country, an international insurance policy, worker's compensation insurance, automobile insurance (whether direct or third party), and/or disability coverage, and Services received are covered by any such policies/programs, benefits will be reduced under this Policy to avoid duplication of available benefits. In no event will more than 100% of the Allowable Charges and/or Maximum Benefit for the Covered Services be paid or reimbursed. It is the duty of the Insured Person to inform us of all other coverages. The Insurer has full right of Subrogation. To determine the primary policy, the following guidelines will be used:

- If the Insured Person has two international policies, the policy which has been in effect with the longest effective date would be primary.
- If no other international policy is available and the Insured Person travels outside the Home Country, this Policy would be primary.

Subrogation

When Insurer pays for expenses that were the result of alleged negligence, or which arise out of any claim or cause of action which may accrue against any third party responsible for Injury or death to the Insured Person, the Insurer has the right to equitable restitution and will advance benefits if the Insured Person agrees to the following:

- The Insured Person and his/her attorney, for the exclusive benefit of the Insurer, must hold any settlement received in trust.
- The Insured Person will reimburse the Insurer out of the Insured Person's recovery for all benefits paid by Insurer. Insurer will be reimbursed in full prior to the Insured Person receiving any monies recovered from any party or their insurer as a result of a judgment, settlement or otherwise. The duty and obligation to reimburse the Insurer also applies to any money the Insured Person receives from any underinsured or uninsured motorist policy of insurance. The Insured Person is obligated to repay the Insurer even if the Insured Person is not fully compensated or made whole from any money he/she receives. The Insured Person must include the Insurer's name as a co-payee on any settlement check. Insurer is paying benefits in reliance upon the Insured Person's agreement to the terms contained in this section of this Policy.
- Insurer has the right to the Insured Person's full cooperation in any case involving the alleged negligence of a third party. In such cases, the Insured Person is obligated to provide us with whatever information, assistance and records we may require to enforce our rights in this provision. The Insured Person further agrees that in the event that the Insurer has reason to believe that it may have a Subrogation lien, we may require the Insured Person to complete a Subrogation questionnaire, sign an acknowledgment of the Insurer's Subrogation rights and an agreement to provide ongoing information before the Plan Administrator pays, or continues payments of claims according to its terms and conditions. Upon receipt of the requested materials, the Insurer will commence or continue payments of claims according to its terms and conditions provided that said payment of claims in no way prejudices the Insurer's rights.
- The Insurer may, but is not obligated to, take any legal action it sees fit against the third party or the Insured Person, to recover the benefits Insurer has paid. The Insurer's exercise of this right will not affect the Insured Person's right to pursue other forms of recovery, unless the Insured Person and his/her legal representative consent otherwise.
- In the event that the Insurer determines that a Subrogation recovery exists, the Plan Administrator retains the right to employ the services of an attorney to recover money due to Insurer. The Insured Person agrees to cooperate with the

attorney who is pursuing the Subrogation recovery. The compensation that the Plan Administrator's attorney receives will be paid directly from the dollars recovered for the Insurer.

- The Insurer specifically states that it has no duty or obligation to pay a fee to the Insured Person's attorney for the attorney's Services in making any recovery on behalf of the Insured Person.
- The Insured Person is obligated to inform their attorney of the Subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Insurer receiving less than the full amount of its lien without the written approval of the Plan Administrator.
- The Insured Person further agrees that he/she will not release any third party or their insurer without prior written approval from the Plan Administrator and will take no action which prejudices the Insurer's Subrogation rights.
- The Insured Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Insurer's lien or right to Reimbursement.
- The Insurer retains discretionary authority to interpret this and all other Policy provisions and the discretionary authority to determine the amount of the lien.
- In the United States, the Insurer pays secondary to any and all personal insurance protection (PIP), medical payment to others (Med-Pay), no-fault coverage or governmental reimbursement programs, including, but not limited to, state crime victim compensation programs, which reimburse victims for crime-related expenses. The Insurer has no duty or obligation to pay any claims until PIP, Med-Pay, no-fault coverage or reimbursement to the Insured Person is exhausted. In the event that the Plan Administrator pays claims that should have been paid by PIP, Med-Pay, no-fault coverage or a state compensation program, the Insurer has a right of recovery from the insurance carrier or Insured Person, as applicable.

Excess Insurance

No benefits are payable for any expense incurred for an Accident or Illness which has been paid or is payable by other valid and collectible insurance or governmental reimbursement programs. Benefits will only be paid under this Policy on the unpaid balances after the other insurance has paid or the allowable reimbursement has been made.

Facility of Payment

Whenever payments which should have been made by us are made by any other person, plan, or organization, we shall have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we shall determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Policy and, to the extent of such payments, we shall be fully discharged from liability.

Plan Manager and Underwriter

This plan is underwritten by Davies Insurance Limited for and on behalf of the WellAway Limited Insurance Agency (Registration No. 49191) and WellAway SAC, and Arch Reinsurance Europe Underwriting dac rated "A+" (Excellent) by Standard & Poor's and Fitch ratings. The Plan administrator is PayerFusion Holdings, LLC, a licensed third-party administrator in the United States.

Claims Appeal Procedures

Insurer will provide a written explanation of the reason if it denies, in whole or in part, a claim for benefits under this Policy. If there is any question about the settlement or denial of a claim, the Insured Person will have the right to request a full and fair review of that claim. The process is as follows:

- Within sixty (60) days of receiving a claim denial, the Insured Person must write to the Insurer or Plan Administrator stating the reasons for the appeal and any additional information to support the claim.
- The Insured Person must include in the appeal the following information: the Appeal Form, the Policy number, the Insured Person's name for whom the claim was made, the Provider, the amount of the claim, the date of service, and the date it was denied.
- The appeal will be reviewed and within an additional sixty (60) days of receiving the completed appeal documents, the Insurer or Plan Administrator will notify the Insured Person by mail of the final decision and the specific reason for the decision.
- You must send copies of all correspondence regarding claim appeals to our Plan Administrator.

To File a Complaint

We aim to keep our customers satisfied; however, we understand that there are instances whereby we may not be able to meet your expectations. For a formal complaint, please contact us by post, telephone or e-mail.

WellAway Limited
Victoria Place
31 Victoria Street, 5th Floor
PO Box HM 1624
Hamilton, HM GX, Bermuda
Phone: 1-441-296-0651
Email: Conciergecare@wellaway.com
Website: www.wellaway.com

Our Contact Numbers

For a ConciergeCare Counselor, to request Pre-Authorization, or to check on the status of a claim, we can be reached at the following numbers:

PayerFusion Holdings, LLC
United States: +1-855-773-7810
International: +1-786-453-4008 (collect) or
E-mail: Conciergecare@payerfusion.com

For Enrollment inquiries: enrollment@wellaway.com
Phone: +1-441-296-0651