Medical Insurance Services Group
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http://service.hccmis.com
hccmis.com

STUDENTSECURE® BUDGET

DESCRIPTION OF COVERAGE

4521150518

CONTENTS

IMPORTANT NOTICE AND DISCLAIMER CONCERNING THE UNITED STATES PATIENT PROTECTION AND AFFORDABLE CARE ACT

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." PPACA also requires certain employers to offer PPACA compliant insurance coverage to their employees. Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and on certain employers who do not offer PPACA compliant insurance coverage to their employees. In some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. **You** should consult **your** attorney or tax professional to determine whether this policy meets any obligations **you** may have under PPACA.

DESCRIPTION OF COVERAGE SUMMARY

This Description of Coverage is a summary of the provisions contained in Master Policy No.181920-STU. For a complete copy of the Master Policy, please contact Tokio Marine HCC Medical Insurance Services Group.

This Description is to help **you** understand the insurance that **your** certificate provides. It details the key features, benefits, limitations, exclusions, definitions, Schedule of Benefits and Limits, and any endorsements, applying to **your certificate**.

The levels of coverage which apply to **your** coverage are detailed in the Schedule of Benefits and Limits.

IMPORTANT FEATURES OF **YOUR** TRAVEL INSURANCE

CANCELLATION

We hope **you** are happy with the cover this policy provides. However, if after reading it, this insurance does not meet with **your** requirements, please notify **us** of **your** wish to cancel and **we** will refund **your** premium.

Premiums will be refunded in full if a cancellation request is received prior to the **certificate effective date**.

Premiums may be refunded after the **certificate effective date** subject to the following provisions:

1. A $25 cancellation fee will apply for administrative costs incurred by **us**; and
2. Only premium for unused whole-months, if paying in monthly installments, or unused days, if paid in full, of the plan will be refunded; and
3. **You** cannot have filed any claims to be eligible for premium refund; and
4. No refund of premium shall be granted after 60 days.

U.S. PREFERRED PROVIDER ORGANIZATION (PPO)

This insurance policy offers the option of a PPO network for medical treatment received in the United States. If **you** choose to seek treatment from a PPO provider, billed charges for eligible expenses may be reduced and **we** will remit payment directly to the provider. Additionally, **we** will apply the in-network **coinsurance** applicable to the expenses.

You may review a listing of **hospitals**, **physicians** and other medical service providers included in the PPO Network for the area where **you** will be receiving treatment by accessing the Internet website for Tokio Marine HCC - MIS Group: www.hccmis.com. For assistance locating a provider, contact us at 1-800-605-2282.

CLAIMS

This insurance policy has in it a Claims Procedure which tells **you** what steps **you** must take to file a claim, and explains **our** obligations to **you**. Beginning on the last day of **your** certificate period, **you** shall have 60 days to provide **us** proof of claim.

APPEALS AND COMPLAINTS

This insurance policy has in it an Appeals and Complaints Procedure which tells **you** what steps **you** can take if **you** wish to make an appeal or complaint.

DEFINITIONS

This insurance policy has defined terms, indicated by bolded words (excluding headers). The defined terms may be found in the relevant benefit section or in the general definitions.

PRE-EXISTING CONDITIONS

This insurance policy excludes coverage for **pre-existing conditions** during the first twelve (12) months of the coverage, except charges resulting directly from an Acute Onset of Pre-existing Condition, Emergency Medical Evacuation, or Repatriation of Remains, subject to the limits set forth in the Schedule of Benefits and Limits.

This policy defines a **pre-existing condition** and provides the description of the Acute Onset of Pre-Existing Conditions benefit.

DATA PROTECTION

We respect individual privacy and value **your** confidence. **We** restrict access to personal information to employees/partners who need to know that information in order to perform their jobs. Any employee that **we** determine is in violation of this policy will be subject to disciplinary action, up to and including termination and criminal prosecution.

We will not disclose **your** personal information to third parties outside Tokio Marine HCC and **our** partners unless ordered to do so to comply with the law of the countries in which **we** do business or when complying with the legal process.

RIGHTS OF THIRD PARTIES

You may assign benefits under this insurance to a **hospital**, **physician** or other provider. Any assignment shall not confer upon such **hospital**, **physician** or other provider, any right or privilege granted to **you** under this insurance except for the right to receive benefits, if any, which are determined to be due and payable hereunder. No **hospital**, **physician** or other provider shall have any direct or indirect claim or right of action against **us**.

LAW AND JURISDICTION

No action of law or equity may be brought to recover benefits under this insurance until 60 days after written proof of claim has been provided to **us**. No such action may be brought after the end of three (3) years after the time written proof of claim is required to be furnished. The validity, interpretation, and performance of this agreement shall be governed by and construed in accordance with the laws of Bermuda.

TOKIO MARINE HCC MEDICAL INSURANCE SERVICES GROUP ("MIS GROUP")

A subsidiary of Tokio Marine HCC, HCC Lloyd's Syndicate 4141 is managed by HCC Underwriting Agency Ltd which is authorized by the Prudential Regulation Authority (PRA) and regulated by the Financial Conduct Authority (FCA) and the PRA. Registered in England and Wales No. 04632146. Registered office: 1 Aldgate, London EC3N 1RE, United Kingdom. Lloyd's is authorised as an insurer in Spain by the Spanish insurance regulatory authority (Dirección General de Seguros y Fondos de Pensiones) under reference L0017.

These details can be checked on the Financial Services Register by visiting: www.fca.org.uk or contacting the Financial Conduct Authority on 0800 111 6768.

MEMBER ELIGIBILITY

ELIGIBILITY

1. **You** must be under age 65; and
   a. A **full-time student** at a college or university (excluding online colleges and universities); or
   b. Within 31 days of being a **full-time student** at a college or university; or
   c. A student under age 19 enrolled in a secondary school; or
   d. A **full-time scholar** affiliated with an educational institution and performing work or research for at least 30 hours per week; and
2. **You** must be residing outside **your home country** for the purpose of pursuing international educational activities; and
3. **You** must not have obtained residency status in **your host country**; and
4. If in the U.S., **you** must hold a valid education-related visa. A copy of the I-20 or DS2019 may be requested.

J-1 and F-1 visa holders: The **full-time student/scholar** status requirement is waived within the U.S. if **you** have a valid F-1 visa (including OPT) or a J-1 visa. Full-time status requirements remain in force for individuals holding M-1, or other category visas.

CERTIFICATE EFFECTIVE & TERMINATION DATES

CERTIFICATE EFFECTIVE DATE

Insurance hereunder is effective on the later of:

1. The moment **we** receive an application and correct premium if the application and payment is made online or by fax;
2. 12:01am U.S .Eastern Time on the date we receive an application and correct premium if the application and payment is made by mail; The moment **you** depart from **your home country**; or
3. 12:01am U.S. Eastern Time on the date requested on the application.

CERTIFICATE TERMINATION DATE

Insurance hereunder terminates on the earlier of:

1. 11:59pm U.S. Eastern Time on the last day of the period for which premium has been paid;
2. 11:59pm U.S. Eastern Time on the date requested on the application;
3. 12:01am U.S. Eastern Time on the date **you** no longer meet eligibility requirements; or
4. The moment of arrival upon **your** return to **your home country** (unless **you** have started a benefit period or are eligible for home country coverage).

BENEFIT PERIOD & HOME COUNTRY COVERAGE

BENEFIT PERIOD

While the **certificate** is in effect, the benefit period does not apply. Upon termination of the **certificate**, in accordance with this provision, **we** will pay eligible medical expenses for up to 60 days beginning on the first day of diagnosis or treatment of a covered **injury** or **illness** while **you** are outside **your home country** and while this **certificate** is in effect. The benefit period applies only to eligible medical expenses related to a condition for which **you** are hospitalized as an **inpatient** on the termination date of the **certificate**.

In the event **you** begin a benefit period while the **certificate** is in effect, and the **certificate** terminates because **you** return to **your home country**, **we** will pay eligible medical expenses which are incurred in **your home country** during the benefit period. Home country coverage applies only to eligible medical expenses for which **you** are hospitalized as an **inpatient** on the termination date of the **certificate**.

INCIDENTAL HOME COUNTRY COVERAGE

For every three month period during which **you** are covered, **you** are eligible for up to a maximum of 15 days of coverage in **your** home country for eligible medical expenses. Any benefit accrued under a single three month period does not accumulate to another period. Failure to continue **your** international trip or **your** return to **your home country** for the sole purpose of obtaining treatment for an **illness** or **injury** that began while traveling shall void any home country coverage provided under the terms of this agreement.

For all non-U.S. citizens electing coverage "Excluding the U.S." and for all U.S. citizens or residents, no coverage is provided within the U.S., except for U.S. citizens or residents during an eligible incidental home country visit or an eligible benefit period.

Except for a benefit period, coverage provided under this Master Policy is for a maximum duration of 364 days. Any extension is based upon the eligibility rules in force and is solely at **our** discretion.

Notwithstanding the foregoing, coverage under all plans shall terminate on the date **we**, at **our** sole option, elect to cancel all **members** of the same sex, age, class or geographic location, provided **we** give no less than 30 days advance written notice by mail to **your** last known address.

SCHEDULE OF BENEFITS AND LIMITS

Plan Details	
Overall Maximum Limit	$500,000
Maximum per Injury / Illness	$250,000
Deductibles (except Emergency Room)	$45 per **injury** or **illness** within the Preferred Provider Organization (PPO) network or **student health center**; otherwise $90 per **injury** or **Illness**. If treatment received outside of U.S., $45 per **illness** or **injury**.
Emergency Room Deductible (claims incurred in U.S. only)	$350 for treatment received in an emergency room
Coinsurance - Claims Incurred in U.S.	
In-Network Payment	**Within the PPO: We** will pay 80% of the next $25,000 of eligible expenses, after the deductible, then 100% to the overall maximum limit.
Out-Of-Network Payment	**Outside the PPO: Usual, reasonable, and customary. You** may be responsible for any charges exceeding the payable amount.
Coinsurance - Claims Incurred outside U.S.	**We** will pay 100% of eligible expenses after the deductible up to the overall maximum limit.

Eligible expenses are subject to **deductible**, **coinsurance**, overall maximum limit, and are per **certificate period** unless specifically indicated otherwise.

Benefit	Limit
Hospital Room and Board	Average semi-private room rate, including nursing services

Intensive Care Unit	Up to the overall maximum limit
Local Ambulance	Up to $500 per **injury** or **illness**, when covered **illness** or **injury** results in hospitalization as inpatient. - *not subject to coinsurance*
Outpatient Treatment	Up to the overall maximum limit
Outpatient Prescription Drugs	50% of actual charges - *not subject to deductible or coinsurance*
Outpatient Physical Therapy & Chiropractic Care	Up to $50 per visit per day - *not subject to coinsurance* Must be ordered in advance by a **physician** and not obtained at a **student health center**
Intercollegiate, Interscholastic, Intramural, or Club Sports	Up to $3,000 maximum per **injury** or **illness**, medical expenses only
Mental Health Disorders (Includes **drug abuse** and **alcohol abuse**)	Treatment must not be provided at a **student health center**. **Outpatient**: Up to $50 maximum per day, $500 maximum. **Inpatient**: Up to $10,000
Maternity Care for a Covered Pregnancy	Up to $5,000.
Nursery Care of Newborn	Up to $250 - *not subject to coinsurance*
Therapeutic Termination of Pregnancy	Up to $500 - *not subject to coinsurance*
Dental Treatment due to Accident	Up to $250 maximum per tooth; $500 maximum per certificate period - *not subject to coinsurance*
Emergency Dental *(Acute Onset of Pain)*	Up to $100 - *not subject to deductible or coinsurance*
Acute Onset of Pre-existing Condition *(Excludes chronic and congenital conditions)*	Up to $25,000 lifetime maximum for eligible medical expenses
Terrorism	Up to $50,000 lifetime maximum, eligible medical expenses only.
All Other Eligible Medical Expenses	Up to the overall maximum limit
Emergency Travel Benefits	**Limit**
Emergency Medical Evacuation	Up to $250,000 lifetime maximum - *not subject to deductible, coinsurance, or overall maximum limit*
Repatriation of Remains	Up to $25,000 lifetime maximum - *not subject to deductible, coinsurance, or overall maximum limit*
Emergency Reunion	Up to $1,000, subject to a maximum of 15 days - *not subject to deductible, coinsurance, or overall maximum limit*

Certificate Period means the period of time beginning on the date and time of the **certificate effective date** and ending on the date and time of the **certificate termination date**.

Coinsurance means **your** payment of eligible expenses at the percentage specified in the Schedule of Benefits and Limits.

Deductible means the dollar amount of eligible expenses, specified in the Schedule of Benefits and Limits that **you** must pay per **certificate period** before eligible expenses are paid.

Usual, Reasonable and Customary means the lesser of the following:

1. One and a half times (150%) of the charges payable under the United States Medicare program, for claims incurred outside the PPO network within the U.S., or
2. Most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are reasonable. What is defined as **usual, reasonable and customary** charges will be determined by **us**. In determining whether a charge is **usual, reasonable and customary**, **we** may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the **illness** or **injury** being

treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors **we**, in the reasonable exercise of discretion, determine are appropriate.

U.S. PREFERRED PROVIDER ORGANIZATION (PPO) REQUIREMENTS

Nothing contained in this insurance restricts or interferes with **your** right to select the **hospital**, **physician** or other medical service provider of **your** choice. Nothing contained in this insurance restricts or interferes with the relationship between **you** and the **hospital**, **physician** or other providers with respect to treatment or care of any condition, nor **your** right to receive, at **your** own expense, services and/or supplies that are not covered under this insurance.

To comply the with United States Preferred Provider Organization requirements, **you** must receive medical treatment from PPO providers while in the United States. If **you** choose to seek treatment from a PPO provider, **we** will apply the **coinsurance** applicable to the expenses.

You may review a listing of **hospitals**, **physicians** and other medical service providers included in the PPO Network for the area where **you** will be receiving treatment by accessing the Internet website for Tokio Marine HCC - MIS Group: www.hccmis.com. For assistance locating a provider, contact us at 1-800-605-2282.

CLAIM PROCEDURES

You must submit a claim for any expenses to be paid by **us**. This includes treatment or services for which the medical provider will bill **us** directly. No payments will be made by **us** without **you** first submitting a claim.

Notice of claim, Claimant's Statement and Authorization, and proof of claim must be mailed to:

Tokio Marine HCC - MIS Group
P.O. Box 2005
Farmington Hills, MI 48333-2005
USA

PROOF OF CLAIM

When **we** receive notice of a claim, **we** will provide **you** with forms for filing proof of claim. The following is considered to be proof of claim:

1. A completed and signed Claimant's Statement and Authorization form, together with any/all required attachments;
2. Original itemized bills from **physicians**, **hospitals** and other medical providers; and
3. Original receipts for any expenses which have already been paid by **you** or on **your** behalf.

Beginning on the last day of **your certificate period, you** shall have **60 days** to provide us **proof of claim** (unless medical services were rendered after the certificate termination date, in which case **you** shall 60 days from the date the claim is incurred). Subsequent to receipt of **proof of claim**, **we** may, at **our** sole discretion, request and require additional information, including but not limited to medical records, necessary to confirm the validity of any claim prior to payment thereof.

CLAIMS COOPERATION

You shall provide assistance and co-operate with **us** or **our** representatives in obtaining any other records **we** or they feel necessary to evaluate the incident or claim. Following notification of a claim, **you** shall provide, when asked, all authorizations necessary to obtain **your** medical records. If **you** do not co-operate with **us** and/or **our** investigation of the claim, **we** shall not be liable to pay any claim.

ACCESS TO ADDITIONAL MATERIALS

You shall provide **us,** or **our** designated representatives, all information, documentation, medical information that **we** or they may reasonably require during the term of this policy, or until all claims have been resolved, whichever is later.

OTHER INSURANCE

We shall not pay any claim if there is other insurance which would, or would but for the existence of this insurance, pay such claim. This insurance will apply with respect to expenses in excess of the amount paid or payable under such other insurance. **We** shall not pay any claim in respect to care, treatment, services or supplies furnished by any program or agency funded by any government.

ARBITRATION

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration by the American Arbitration Association in accordance with its Consumer Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Where any dispute is by this provision referred to arbitration, the making of an award shall be a condition precedent to any right of action against **us**.

APPEAL AND COMPLAINTS PROCEDURE

APPEALING A CLAIM

In the event **we** deny all or part of a claim under this insurance, **you** may file a written appeal with **us**. The written appeal must include sufficient information to identify the claim under appeal and must specify the reason(s) for the appeal with supporting documentation, if applicable.

Please provide your written appeal online or by postal mail at the following:

http://service.hccmis.com/ or Tokio Marine HCC - MIS Group
P.O. Box 2005
Farmington Hills, MI 48333-2005
USA

When **we** receive the appeal, **we** will review the claim and a written response will be sent to **you**. After **you** receive **our** response to the appeal, **you** may initiate a second appeal. With **our** receipt of the second appeal, medical and/or claims personnel who were not involved in the original claim determination or the initial appeal will review the claim. A final determination will be made and a letter will be sent to **you**.

Please note that appealing a claim is not a requirement to following the complaints procedure detailed below.

COMPLAINTS PROCEDURE

We are dedicated to providing a high-quality service and want to ensure that it is maintained at all times. If **you** feel that **we** or another party connected with this policy have not offered a first class service please contact **us** and **we** will do our best to resolve the problem.

Please provide your written complaint online or by postal mail at the following:

http://service.hccmis.com/ or Tokio Marine HCC - MIS Group
P.O. Box 2005
Farmington Hills, MI 48333-2005
USA

For both appeals and complaints, **you** will be contacted within 3 (three) business days to inform **you** of what action is being taken. **We** will try to resolve the problem and give **you** an answer within four weeks. If it will take longer than four weeks **we** will tell **you** when **you** can expect an answer. If **you**

have not been given an answer within 8 (eight) weeks **we** will tell **you** how **you** can take **your** complaint to the Financial Ombudsman Service for review. This complaints procedure does not affect any legal right **you** have to take action. Once **you** have received **your** final response from **us**, and if **you** are still not satisfied **you** can contact the Financial Ombudsman Service:
Financial Ombudsman Service
Exchange Tower, Harbour Exchange Square, London, E14 9SR
Phone: +44 (0) 20 7964 0500
Email: complaint.info@financial-ombudsman.org.uk

If you have purchased your policy online or by other electronic means within the European Union (EU) you may also make your complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is: http://ec.europa.eu/odr

PRE-EXISTING MEDICAL CONDITIONS

Charges resulting directly or indirectly from any **pre-existing conditions** are excluded from this insurance during the first twelve (12) months of coverage, except charges resulting directly from an Acute Onset of Pre-existing Condition, an Emergency Medical Evacuation, or Repatriation of Remains, subject to the limits set forth in the Schedule of Benefits and Limits.

Pre-existing Condition means any

(1) condition for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received during the 12 months immediately preceding the certificate effective date;

(2) condition that had manifested itself in such a manner that would have caused a reasonably prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 12 months immediately preceding the certificate effective date;

(3) **injury**, **illness**, sickness, disease, or other physical, medical, mental, or nervous conditions, disorder or ailment (whether known or unknown) that, with reasonable medical certainty, existed at the time of application or within the 12 months immediately preceding the certificate effective date.

ACUTE ONSET OF PRE-EXISTING CONDITION

YOU ARE COVERED:

1. Charges for a sudden and unexpected outbreak or recurrence of a **pre-existing condition(s)** which:
   a. Occurs spontaneously and without advance warning either in the form of **physician** recommendations or symptoms; and
   b. Is of short duration; and
   c. Is rapidly progressive; and
   d. Requires urgent care.

YOU ARE NOT COVERED unless **you** fulfill the following condition:

1. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence.

YOU ARE NOT COVERED IF:

1. The Acute Onset of a Pre-existing Condition(s) occurs before the certificate effective date; or
2. The pre-existing condition is a chronic or congenital condition or that gradually becomes worse over time; or
3. The charges are for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the certificate effective date; or
4. Expenses arise directly or indirectly from anything in the General Exclusions.

MEDICAL & REPATRIATION EXPENSES

Subject to the limits set forth in the Schedule of Benefits and Limits, and subject to the conditions and restrictions contained in this provision, **we** will pay the following expenses incurred while this insurance is in effect.

MEDICAL EXPENSES

YOU ARE COVERED:

1. Charges made by a **hospital** for:
   a. Daily room and board and nursing services not to exceed the average semi-private room rate; and
   b. Daily room and board and nursing services in Intensive Care Unit; and
   c. Use of operating, treatment or recovery room; and
   d. Services and supplies which are routinely provided by the hospital to persons for use while inpatients; and
   e. Emergency treatment of an **injury** or **illness**, even if **hospital** confinement is not required. However, charges for use of the emergency room itself within the U.S. will be subject to deductible as provided under the Schedule of Benefits and Limits.
2. **Surgery** at an **outpatient** surgical facility, including services and supplies.
3. Charges made by a **physician** for professional services, including **surgery**. Charges for an assistant surgeon are covered up to 20% of the **usual, reasonable and customary** charge of the primary surgeon, but standby availability will not be deemed to be a professional service and therefore is not covered hereunder.
4. Dressings, sutures, casts or other supplies which are **medically necessary** and administered by or under the supervision of a **physician**, but excluding nebulizers, oxygen tanks, diabetic supplies, supplies that are available over the counter or without prescriptions, and support or brace appliances.
5. Diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).
6. Artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof.
7. Reconstructive **surgery** when the **surgery** is directly related to **surgery** which is covered hereunder.
8. For radiation therapy or treatment and chemotherapy.
9. Hemodialysis and the charges by the **hospital** for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
10. Oxygen and other gasses and their administration by or under the supervision of a **physician**.
11. Anesthetics and their administration by a **physician**.
12. Drugs which require prescription by a **physician** for treatment of a covered **injury** or **illness**, but excluding drugs: prescribed for the treatment of diabetes, replacement of lost, stolen, damaged, expired or otherwise compromised drugs.
13. Care in a licensed **extended care facility** upon direct transfer from an acute care **hospital**.
14. **Home nursing care** in bed by a qualified licensed professional, provided by a **home health care agency** upon direct transfer from an acute care **hospital** and only in lieu of **medically necessary inpatient** hospitalization.
15. Emergency local ambulance transport necessarily incurred in connection with **injury** or **illness** resulting in **inpatient** hospitalization.
16. Emergency dental treatment and dental **surgery** necessary to restore or replace sound natural teeth lost or damaged in an **accident** which was covered under this insurance.
17. Emergency dental treatment necessary to resolve **acute onset of pain**, provided treatment is obtained within 24 hours of the **acute onset of pain**.
18. **Medically necessary** rental of **durable medical equipment** (consisting of a standard basic hospital bed and or a standard basic wheelchair) up to the purchase prices.
19. Outpatient physical therapy if prescribed by a **physician** for treatment of a covered **injury** or **illness**.

20. Routine and **medically necessary** care of newborns as provided in the Schedule of Benefits, provided that the delivery of the newborn is covered hereunder.
21. Pre-natal care, delivery of newborn, and post-natal care related to a **covered pregnancy** which began after the effective date of coverage.
22. For treatment of **mental health disorders** including **drug abuse** and **alcohol abuse**.

YOU ARE NOT COVERED IF:
1. Expenses arise directly or indirectly from anything in the General Exclusions.

EMERGENCY MEDICAL EVACUATION

YOU ARE COVERED:
1. Emergency air transportation to a suitable airport nearest to the **hospital** where **you** will receive treatment; and
2. Emergency ground transportation necessarily preceding emergency air transportation; and from the destination airport to the **hospital** where **you** will receive treatment.

YOU ARE NOT COVERED unless **you** fulfill the following conditions:
1. The evacuation is recommended by the attending **physician** who certifies that it is **medically necessary** and that transportation by any other method would result in the loss of **your** life or limb; and
2. The evacuation is agreed upon by **you** or **your relative**; and
3. Travel arrangements, excluding Emergency Local Ambulance, are approved in advance and coordinated by **us**.

YOU ARE NOT COVERED IF:
1. The **illness** or **injury** giving rise to the expense is not covered under this insurance; or
2. **Medically necessary** treatment, services and supplies can provided locally; or
3. If transportation by any other method would not result in the loss of **your** life or limb; or
4. The condition giving rise to the Emergency Medical Evacuation did not occur spontaneously and without advance warning, either in the form of **physician** recommendation or symptoms which would have caused a prudent person to seek medical attention prior to the onset of the emergency; or
5. Expenses are directly or indirectly from anything in the General Exclusions.

We will provide Emergency Medical Evacuation only to the nearest **hospital** that is qualified to provide the **medically necessary** treatment, services and supplies to prevent **your** loss of life or limb.

The timeliness of arrangements can be affected by circumstances which are not within **our** control such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. **We** shall not be held liable for any delays that are not within **our** direct and immediate control.

Notwithstanding the foregoing, and if **you** are visiting the U.S., **we** will pay for expenses to return **you** to **your home country** if the attending **physician** and **our** medical consultant agree that transfer to the **home country** is more appropriate than transfer to the nearest qualified **hospital**.

REPATRIATION OF REMAINS

YOU ARE COVERED:
1. Air or ground transportation of bodily remains or ashes to the airport or ground transportation terminal nearest **your** principal residence; and
2. Reasonable costs of preparation of the remains necessary for transportation.

YOU ARE NOT COVERED unless **you** fulfill the following conditions:
1. The **illness** or **injury** giving rise to the expense are covered under this insurance; and

2. Travel arrangements are approved in advance and coordinated by **us.**

YOU ARE NOT COVERED IF:
1. Expenses arise directly or indirectly from anything in the General Exclusions.

We are held harmless and shall not be held liable for loss of or any damage or other impairment to bodily remains incurred during the repatriation process or otherwise.

The timeliness of arrangements can be affected by circumstances which are not within **our** control such as: availability of transportation equipment and staff, delays or restrictions on flights caused by mechanical problems, government officials, telecommunications problems, weather and other acts of God. **We** shall not be held liable for any delays that are not within **our** direct and immediate control.

EMERGENCY REUNION

YOU ARE COVERED:

1. The cost of an economy round-trip air or ground transportation ticket for one **relative** for transportation to the terminal serving the area where **you** are hospitalized or are to be hospitalized following Emergency Medical Evacuation; and
2. Reasonable expenses for lodging and meals for the **relative**, which are incurred in the area where **you** are hospitalized for a period not to exceed 15 days.

YOU ARE NOT COVERED unless **you** fulfill the following conditions:
1. **You** have a covered Emergency Medical Evacuation; or
2. **You** are hospitalized as an **inpatient** for at least five days due to a life-threatening covered condition. Emergency Reunion benefits not related to an Emergency Medical Evacuation will be paid only following the end of the minimum five day **inpatient** stay.

YOU ARE NOT COVERED IF:
1. Expenses arise directly or indirectly from anything in the General Exclusions.

SPORTS AND ACTIVITIES

A. INTERCOLLEGIATE, INTERSCHOLASTIC, INTRAMURAL, OR CLUB SPORTS

YOU ARE COVERED:

1. Subject to the limit set forth in the Schedule of Benefits and Limits, **you** are covered for a new injury or illness sustained while covered under this policy and taking part in sanctioned intercollegiate, interscholastic, intramural, or club sports.

YOU ARE NOT COVERED IF:

1. The sports or athletics are not sanctioned by **your** school; or
2. The activity is performed in a professional capacity or for any wage, reward, or profit; or
3. The injury or illness is sustained while **you** are not actively covered hereunder; or
4. Expenses arise directly or indirectly from anything mentioned in the General Exclusions.

B. LEISURE, RECREATIONAL, ENTERTAINMENT, OR FITNESS SPORTS AND ACTIVITIES

YOU ARE COVERED:

1. Subject to the overall maximum limit**, you** are covered for injury or illness sustained while taking part in sports and activities, unless it is excluded below.

   You must ensure the activity is adequately supervised and that appropriate safety equipment (such as protective headwear, life jackets etc.) are worn at all times.

YOU ARE NOT COVERED IF:

1. The sports or athletics involve regular or scheduled practice and/or games; or
2. The activity is performed in a professional capacity or for any wage, reward, or profit; or
3. Expenses arise directly or indirectly from anything mentioned in the General Exclusions; or
4. Any of the excluded items listed below:

- Aviation (except when traveling solely as a passenger in a commercial aircraft)
- Base Jumping
- BMX freestyle
- Bungee Jumping
- Free-Diving
- Hang-Gliding
- Jet Skiing
- Mountaineering where a reasonably prudent person would use ropes or guides or at elevations of 4,500 meters or higher
- Parachuting
- Racing by any Animal, Motorized Vehicle, or BMX
- Skateboarding
- Sky Diving
- Sky Surfing
- Snow Skiing and Snowboarding, except recreational downhill and/or cross country snow skiing or snowboarding (no cover provided while skiing away from prepared and marked in-bound territories and/or against the advice of the local ski school or local authoritative body)
- Spelunking
- Sub Aqua Pursuits involving underwater breathing apparatus unless accompanied by a certified instructor at depths less than 10 meters, or PADI/NAUI certified
- Surfing
- Whitewater Kayaking and Rafting

TERRORISM

YOU ARE COVERED:

1. Eligible Medical Expenses for treatment of **injuries** and **illnesses** resulting from an Act of Terrorism, up to the limit set forth in the Schedule of Benefits and Limits, provided all of the following conditions are met.

YOU ARE NOT COVERED unless **you** fulfill the following conditions:

1. The **injury** or **illness** does not result from the use of any biological, chemical, **cyber**, radioactive or nuclear agent, material, device or weapon;
2. **You** have no direct or indirect involvement in the Act of Terrorism;
3. The Act of Terrorism is not in a country or location where the U.S. Department of State has issued a level 3 or level 4 travel advisory that has been in effect within the 6 months immediately prior to **your** date of arrival; and
4. **You** have not failed to depart a country or location within 10 days following the date a level 3 or level 4 travel advisory forthat country or location is issued by the United States government.

YOU ARE NOT COVERED IF:

1. Loss, damage, cost or expense directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss, damage, cost or expense:
   a. War, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power;
   b. The use of any biological, chemical, **cyber**, radioactive or nuclear agent, material, device or weapon; however, this exclusion shall not apply where **you** are exposed to nuclear radioactive and/or radioactive material for the purpose of medical treatment;
   c. Any Act of Terrorism, not specifically covered above;
   d. Coverage for loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to (a), (b) or (c) above; and
   e. Expenses arise directly or indirectly from anything mentioned in the General Exclusions.

For the purpose of this insurance, an “Act of Terrorism” means an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s) committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

If **we** allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance, the burden of proving the contrary shall be upon **you**.

In the event any portion of this exclusion is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

Cyber means the use or operations, as a means for inflicting harm, of any computer, computer software program, malicious code, computer virus or process or any other electronic system.

GENERAL EXCLUSIONS

Excluded Conditions, Treatments (includes Diagnoses, Tests, and Examinations), Services, Supplies, Acts, Omissions, and/or Events:

1. **Pre-existing Conditions** during the first twelve (12) months of coverage, except charges resulting directly from an Acute Onset of Pre-existing Condition, an Emergency Medical Evacuation, or Repatriation of Remains, subject to the limits set forth in the Schedule of Benefits and Limits.
2. Congenital illnesses.
3. Immunizations, routine physical exams, and other diagnostic labs, x-rays, and procedures for screening or preventative purposes.
4. Dental treatment and treatment of the temporomandibular joint, except for emergency dental treatment necessary to replace sound natural teeth lost or damaged in an accident covered hereunder or for the emergency relief of acute onset of pain.
5. **Mental health disorders** if treatment is obtained at a **student health center**.
6. Physical therapy if treatment is obtained at a **student health center**.
7. Chiropractic treatment, unless ordered in advance by a **physician** for **medically necessary** treatment related to a covered **injury** or **illness,** and not obtained at a **student health center**.
8. Routine pre-natal care, pregnancy, child birth, post-natal care, and nursery care of a newborn, unless directly related to a **covered pregnancy**.
9. Elective termination of pregnancy.
10. Promotion or prevention of conception including but not limited to: artificial insemination, treatment for infertility, sterilization or reversal of sterilization.
11. All **sexually transmitted diseases** and conditions.
12. HIV, AIDS, or ARC, and all diseases caused by and/or related to HIV.
13. Organ or tissue transplants or related services.
14. Self-inflicted **injury** or **illness** and**/**or suicide or attempted suicide whether sane or insane.
15. **Injury** sustained that is due wholly or partially to the effects of intoxication or drugs other than drugs taken in accordance with treatment prescribed by a **physician** and except drugs prescribed for the treatment of **substance abuse**.
16. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a **physician**.
17. Charges resulting from or occurring during the commission of a violation of law, including without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations.
18. Eye **surgery**, such as corrective refractory **surgery**, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
19. Corrective devices and medical appliances, including eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, dentures or dental appliances, and all vision and hearing tests and examinations.
20. Orthoptics and visual eye training.
21. Orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
22. Hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed.
23. Acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, hypertrophic and atrophic conditions of skin, nevus.
24. Sleep apnea or other sleep disorders.
25. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
26. Psychometric, intelligence, competency, behavioral and educational testing.
27. While confined primarily to receive **custodial care**, educational or rehabilitative care, or any medical treatment in any establishment for the care of the aged, except rehabilitative care received upon direct transfer from an acute care **hospital**.

28. Cosmetic or aesthetic reasons, except for reconstructive **surgery** when such **surgery** is directly related to and follows a **surgery** which was covered hereunder.
29. Modifications of the physical body intended to improve the psychological, mental or emotional well-being, including but not limited to sex-change **surgery**.
30. Obesity or weight modification, including but not limited to wiring of the teeth and all forms of intestinal bypass **surgery**.
31. Exercise programs, whether or not prescribed or recommended by a **physician**.
32. Incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
33. Charges resulting from a disease outbreak in a country or location for which the U.S. Centers for Disease Control and Prevention (CDC) has issued a Level 3 Travel Warning if a) the warning has been in effect within the 6 months immediately prior to **your** date of arrival, or b) within 10 days following the date the warning is issued **you** have failed to depart the country or location.
34. **Investigational, experimental or for research** purposes.
35. Complications or consequences of a treatment or condition not covered hereunder.
36. Incurred outside **your certificate period**.
37. Submitted to **us** for payment more than 60 days after the last day of the **certificate period**.
38. Exceeding **usual, reasonable and customary**.
39. Not **medically necessary**.
40. Not administered by or ordered by a **physician**.
41. Provided by a **relative**, family member or any person who ordinarily resides with **you**.
42. Provided at no cost to **you**.
43. Telephone consultations or failure to keep a scheduled appointment.
44. When departure from the **home country** is to obtain treatment in the destination country/countries.
45. Travel or accommodations, except as provided for in the Local Ambulance, Emergency Medical Evacuation, Repatriation of Remains, and Emergency Reunion sections of this insurance.
46. Payable under any government system, including the Australian Medicare system.
47. War, military action or while on duty as a member of a police or military force unit.
48. Not included as Eligible Expenses as described herein.

DEFINITIONS

Accident means a sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in physical **injury** to **you**. The cause or one of the causes of such **accident** is external to **your** own body and occurs beyond **your** control.

Acute Onset of Pain (Emergency Dental) means a sudden and unexpected occurrence of pain which occurs spontaneously and without advance warning, either in the form of **physician** or dentist recommendation or symptoms, including pain, which would have caused a prudent person to seek medical or dental attention prior to the onset of pain. Treatment must be obtained within 24 hours of the sudden and unexpected occurrence of pain.

Acute Onset of Pre-existing Condition means a sudden and unexpected outbreak or recurrence of a **pre-existing condition(s)** which occurs spontaneously and without advance warning either in the form of **physician** recommendations or symptoms, is of short duration, is rapidly progressive, and requires urgent care. The Acute Onset of a Pre-existing Condition(s) must occur after the certificate effective date. Treatment must be obtained within 24 hours of the sudden and unexpected outbreak or recurrence. A **pre-existing condition** that is a chronic or congenital condition or that gradually becomes worse over time will not be considered Acute Onset. This benefit does not include coverage for known, scheduled, required, or expected medical care, drugs or treatments existent or necessary prior to the certificate effective date.

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Certificate means the document issued to **you** that provides evidence of benefits payable under the Master Policy.

Certificate Period means the period of time beginning on the date and time of the **certificate effective date** and ending on the date and time of the **certificate termination date**.

Coinsurance means **your** payment of eligible expenses at the percentage specified in the Schedule of Benefits and Limits.

Covered Pregnancy means a pregnancy which began after the effective date of coverage.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist **you** in performing the activities of daily living**.** Custodial care also includes non-acute care for the comatose, semi-comatose, paralyzed or mentally incompetent patients.

Cyber means the use or operations, as a means for inflicting harm, of any computer, computer software program, malicious code, computer virus or process or any other electronic system.

Deductible means the dollar amount of eligible expenses, specified in the Schedule of Benefits and Limits that **you** must pay per **certificate period** before eligible expenses are paid.

Dental Treatment means the care of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Durable Medical Equipment means a standard basic hospital bed and/or a standard basic wheelchair.

Educational or Rehabilitative Care means care for restoration (by education or training) of one's ability to function in a normal or near normal manner following an **illness** or **injury**. This type of care includes, but is not limited to, vocational or occupational therapy and speech therapy.

Emergency means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing **your** life or limb in danger if medical attention is not provided within 24 hours.

Extended Care Facility means an institution, or a distinct part of an institution, which is licensed as a **hospital**, **extended care facility** or rehabilitation facility by the state in which it operates; and is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a **physician** and the direct supervision of a registered nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a **physician**; and provides each patient with active treatment of an **illness** or **injury**. **Extended care facility** does not include a facility primarily for rest, the aged, **substance abuse** treatment, **custodial care**, nursing care or for care of **mental health disorders** or the mentally incompetent.

Full-time Scholar means an individual who is affiliated with an educational institution and is engaging in educational activities for at least 30 hours per week. These activities may include but not be limited to performing research in an area of specialty or teaching for a temporary period of time.

Full-time Student means a student at a college or university who is taking 10 credit hours (undergraduate students) or 6 credit hours (graduate students). Full-time student status for individuals enrolled at colleges or universities that do not use a credit hour system must provide documentation of full-time student status.

Home Country means, for U.S. Citizens, the United States of America, regardless of the location of **your** principal residence. For non-U.S. Citizens, **home country** is the country where **you** principally reside and receive regular mail.

Home Health Care Agency means a public or private agency or one of its subdivisions, which operates pursuant to law and is regularly engaged in providing home nursing care under the supervision of a registered nurse, and maintains a daily record on each patient, and provides each patient with a planned program of observation and treatment by a **physician**.

Home Nursing Care means services provided by a **home health care** agency and supervised by a registered nurse, which are directed toward the personal care of a patient, provided always that such care is provided in lieu of **medically necessary inpatient** care in a **hospital**.

Hospital means an institution which operates as a **hospital** pursuant to law, and is licensed by the state or country in which it operates; and operates primarily for the reception, care and treatment of sick or injured persons as **inpatients**; and provides 24-hour nursing service by registered nurses on duty or call; and has a staff of one or more **physicians** available at all times; and provides organized facilities and equipment for diagnosis and treatment of acute medical conditions on its premises; and is not primarily a rehabilitation facility, long-term care facility, **extended care facility**, nursing, rest, **custodial care** or convalescent home, a place for the aged, drug addicts, alcoholics or runaways; or similar establishment.

Host Country means the country, other than the **home country**, in which **you** will engage in educational pursuits. For legal residents and citizens of the U.S., the host country must be outside the U.S., including the U.S. Virgin Islands, Puerto Rico, Guam, American Samoa, and the Northern Mariana Islands.

Illness means a sickness, disorder, **illness**, pathology, abnormality, ailment, disease or any other medical, physical or health condition. **Illness** does not include learning disabilities, attitudinal disorders or disciplinary problems.

Injury means an unexpected and unforeseen harm to the body caused by an accident that requires medical treatment.

Inpatient means a person who is an overnight resident patient of a **hospital**, using and being charged for room and board.

Intensive Care Unit means a cardiac care unit or other unit or area of a **hospital** that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Investigational, Experimental or for Research Purposes means procedures, services or supplies that are by nature or composition, or are used or applied, in a way which deviates from generally accepted standards of current medical practice.

Medically Necessary means a service or supply which is necessary and appropriate for the diagnosis or treatment of an **illness** or **injury** based on generally accepted current medical practice as determined by **us**. A service or supply will not be considered **medically necessary** if is provided only as a convenience to **you** or the provider, and/or is not appropriate for **your** diagnosis or symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment of an **illness** or **injury**.

Member means an individual who is covered under this insurance.

Mental Health Disorder means a mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioral symptoms; or a disease of the mind or personality, evidenced by abnormal behavior; or a disorder of conduct evidenced by socially deviant behavior. Mental health disorders include: psychosis, depression, schizophrenia, bipolar affective disorder, and those psychiatric illnesses listed in the current edition of the diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Outpatient means a **member** who receives **medically necessary** treatment by a **physician** for **injury** or **illness** that does not require overnight stay in a **hospital**.

Physician means a Doctor of Medicine (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatry (DPM), Doctor of Osteopathy (DO), a licensed Physical Therapist or Physiotherapist, and a Doctor of Psychiatry (Psy.D) and a Doctor of Psychology (Ph.D.). Physician also includes a Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Nurse Midwife or a Physician Assistant (PA) under the direction of a medical doctor. A physician must be currently licensed by the jurisdiction in which the services are provided, and the services must be within the scope of that license and covered under this Master Policy.

Relative means biological or step parent current spouse, biological or stepsiblings, or child or stepchild, age 18 or older.

Routine Physical Exam means and examination of the physical body by a **physician** for preventative or informative purposes only, and not for the diagnosis or treatment of any condition. Routine physical exam also includes diagnostic labs, x-rays, and other procedures for screening, preventative, or informative purposes.

Sexually Transmitted Diseases means diseases including but not limited to syphilis, gonorrhea, chlamydiosis, trichomoniasis, genital herpes, and Human Papillomavirus (HPV).

Student Health Center means a medical facility of an educational institution that provides basic health services for students for a minimum of 10 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (MD, CNP, or RN) for the purpose of assessment and treatment of minor **illnesses** and **injuries** and/or referral to another medical provider.

Substance Abuse means alcohol, drug or chemical abuse, overuse or dependency.

Surgery or Surgical Procedure means an invasive diagnostic procedure, or the treatment of **illness** or **injury** by manual or instrumental operations performed by a **physician** while the patient is under general or local anesthesia.

Therapeutic Termination of Pregnancy means willful termination of pregnancy determined to be **medically necessary** for the wellbeing of the mother.

Usual, Reasonable and Customary means the lesser of the following:

1. One and a half times (150%) of the charges payable under the United States Medicare program, for claims incurred outside the PPO network within the U.S., or
2. Most common charge for similar services, medicines or supplies within the area in which the charge is incurred, so long as those charges are reasonable. What is defined as **usual, reasonable and customary** charges will be determined by **us**. In determining whether a charge is **usual, reasonable and customary**, **we** may consider one or more of the following factors: the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; the severity or nature of the **illness** or **injury** being treated; the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; such other factors **we**, in the reasonable exercise of discretion, determine are appropriate.

You/Your means each insured person named in the **certificate.**

We/Us/Our means Tokio Marine HCC Medical Insurance Services Group.