BENEFIT SUMMARY

Coverage Limit / Maximum Amount for Eligible Medical Expenses			
Certificate Period of Coverage	**Maximum Limit: 365 days**		
Maximum Limit	**Insured Person: $250,000 Spouse and Child: $250,000**		
Per Illness or Injury limit	**Insured Person: $250,000 Spouse and Child: $250,000**		
The per Illness or Injury limits accumulate towards the Maximum Limit.			
Area of Coverage	Worldwide excluding the Insured Person's Country of Residence		
Benefit Plan Features			
Benefit Levels	**United States**	**United States**	**International**
	In-Network	Out-of-Network	International
Deductible for Eligible Medical Expenses			
Deductible • Per Period of Coverage	$100	$100	$100
Coinsurance for Eligible Medical Expenses			
Coinsurance	Plan pays 90% Insured pays 10%	Plan pays 80% Insured pays 20%	Plan pays 100% Insured pays 0%
Out of Pocket Maximum • Per Period of Coverage	$1,000	$1,000	$0
Student Health Center			
Copayment per visit • Not subject to Deductible	$0		
Coinsurance	Plan pays 100% Insured pays 0%		
Pre-certification			
• Interfacility Ambulance Transfer: No coverage if Pre-certification requirements are not met. • Emergency Medical Evacuation: No coverage if not approved by the Company. Refer to the EMERGENCY MEDICAL EVACUATION provision for complete requirements and coverage. • All other Treatments & supplies: 50% reduction of Eligible Medical Expenses if Pre-certification requirements are not met. • Deductible is taken after reduction. • Coinsurance is applied to remainder of the reduced amount. • Refer to the PRE-CERTIFICATION REQUIREMENTS provision for a complete list of services that require Pre-certification.			
Pre-existing Conditions			
Charges resulting directly or indirectly from or relating to any Pre-existing Condition are excluded until the Insured Person has maintained 6 months of continuous coverage under this insurance.			
Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Benefit	**In-Network**	**Out-of-Network**	**International**
Eligible Medical Expenses	90%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Benefit	**In-Network**	**Out-of-Network**	**International**
Physician Visits / Services • Maximum visits per day: 1 • Surgery is not subject to the Maximum visit limit	90%	80%	100%
Hospital Emergency Room • Injury: Not subject to Emergency Room Deductible • Illness: Subject to a $250 Deductible for each Emergency Room visit for Treatment that does not result in a direct Hospital admission.	90%	80%	100%
Teladoc Consultation	• Not subject to Deductible and Coinsurance • Applicable in the United States • Mental or Nervous Disorders are not covered • Coverage for a Teladoc Consultation is not a determination that any specific condition discussed, raised or identified during such consultation is covered under this insurance. The Company reserves the right to decline future claims relating to or arising from any condition discussed, raised or identified during a Teladoc Consultation where the Illness or Injury is otherwise excluded under this Certificate of Insurance		
Hospitalization / Room & Board • Average semi-private room rate • Includes nursing, miscellaneous and Ancillary Services	90%	80%	100%
Intensive Care	90%	80%	100%
Outpatient Surgical / Hospital Facility	90%	80%	100%
Laboratory	90%	80%	100%
Radiology / X-ray	90%	80%	100%
Chemotherapy / Radiation Therapy	90%	80%	100%
Pre-admission Testing	90%	80%	100%
Surgery	90%	80%	100%
Reconstructive Surgery • Surgery is incidental to and follows Surgery that was covered under the plan	90%	80%	100%
Assistant Surgeon • 20% of the primary surgeon's eligible fee	90%	80%	100%
Anesthesia	90%	80%	100%
Durable Medical Equipment	90%	80%	100%
Chiropractic Care • Maximum visits: 20 • Medical order or Treatment plan required	90%	80%	100%

Inpatient or Outpatient Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Benefit	**In-Network**	**Out-of-Network**	**International**
Physical Therapy • Maximum visits: 20 • Maximum visits per day: 1 • Medical order or Treatment plan required	90%	80%	100%
Extended Care Facility • Upon direct transfer from acute care Hospital	90%	80%	100%
Home Nursing Care • Provided by a Home Health Care Agency • Upon direct transfer from an acute care Hospital	90%	80%	100%
Prescription Drugs and Medication Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage			
The following Prescription Drugs and Medication Period of Coverage limit accumulates toward the Maximum Limit			
Period of Coverage limit • Subject to the Coinsurance amounts listed below	• $250,000 per person		
Inpatient and Outpatient Surgery Prescription Drugs and Medication	90%	80%	100%
Emergency Room and Outpatient Office Visits Prescription Drugs and Medication	90%	80%	100%
Retail Pharmacy Prescription Drugs and Medication • Dispensing maximum for Retail Pharmacy: 90 days per prescription	Not Applicable	50%	50%
Mental or Nervous / Substance Abuse Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Inpatient Mental or Nervous / Substance Abuse • Maximum Limit: $10,000 • Not covered if incurred at the Student Health Center	90%	80%	100%
Outpatient Mental or Nervous / Substance Abuse • Maximum Limit per Day: $50 • Maximum Limit: $500 • Not covered if incurred at the Student Health Center	90%	80%	100%

Emergency Services NOT Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Benefit	**In-Network**	**Out-of-Network**	**International**
Emergency Local Ambulance • Period of Coverage Limit per Injury: $350 • Period of Coverage Limit per Illness $350 (resulting in an Inpatient Hospitalization)	100%	100%	100%
Emergency Medical Evacuation • Maximum Limit: $500,000 • Must be approved in advance and coordinated by the Company	100%	100%	100%
Emergency Reunion • Maximum Limit: $50,000 • Maximum Days: 15 • Meal Maximum per Day: $25 • Reasonable and necessary travel costs and accommodations • Must be approved in advance by the Company	100%	100%	100%
Interfacility Ambulance Transfer • Up to the per Illness or Injury limit • Services rendered in the United States • Transfer must be a result of an Inpatient Hospitalization	100%	100%	Not Applicable
Political Evacuation and Repatriation • Maximum Limit: $10,000 • Must be approved in advance by the Company	100%	100%	100%
Repatriation for Medical Treatment • Maximum Limit: $100,000 (in addition to the plan per Illness or Injury limit) • Approved in advance and coordinated by the Company • Refer to the REPATRIATION FOR MEDICAL TREATMENT provision for further details	100%	100%	100%
Return of Mortal Remains • Maximum Limit: $50,000 • Local Burial / Cremation at place of death ○ Maximum Limit: $5,000 • Return of Insured Person's Mortal Remains to Country of Residence • Must be approved in advance by the Company	100%	100%	100%

Other Services Subject to Deductible and Coinsurance unless otherwise noted Eligible Medical Expenses are limited to Usual, Reasonable and Customary Limits per Period of Coverage unless stated as Maximum Limit			
Benefit	**In-Network**	**Out-of-Network**	**International**
Accidental Death & Dismemberment • Not subject to Deductible and Coinsurance • Death must occur within 90 days of the Accident	Accidental Death Principal Sum: Insured Person $25,000 Spouse $10,000 Child $5,000		
	Accidental Dismemberment: Loss — Percent of Principal Sum Sight of one eye 50% One hand or one foot 50% One hand and sight of one eye 100% One foot and sight of one eye 100% One hand and one foot 100% Both hands or both feet 100% Sight of both eyes 100%		
Dental Treatment • Period of Coverage Limit: $350 (Treatment due to Unexpected pain to sound, natural teeth) • Period of Coverage Limit per Injury: $500 (Non-emergency Treatment by a Dental Provider due to an Accident)	Not Applicable	90%	100%
Traumatic Dental Injury • Treatment at a Hospital Facility due to an Accident • Additional Treatment for the same Injury rendered by a Dental Provider will be paid at 100%	90%	80%	100%
Incidental Trip • Maximum Days: 14 • Insured Person's Country of Residence is not the United States • Refer to the INCIDENTAL TRIP provision for further details	90%	80%	100%
Personal Liability • Secondary to any other insurance • No coverage for Injury to a related Third Party or damage to related Third Person's property • Refer to the PERSONAL LIABILITY provision for further details and requirements	Combined Maximum Limit: $10,000		
	Injury to Third Person: • Per Injury Deductible: $100 Damage to Third Person's property: • Per damage Deductible: $100		
Terrorism • Not subject to Deductible and Coinsurance • Maximum Limit: $50,000	100%	100%	100%