

LEWERMARK PLUS

medical benefits plan for international students

COVERAGE FOR INTERNATIONAL STUDENTS THAT EVERYONE CAN UNDERSTAND



Making a World of Difference

Benefits for Accident and Sickness, exclusively for Loyola University

- 100% coverage after Copayment for most expenses
- Medical evacuation benefit
- Repatriation benefits
- Coverage complies with Title IX
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Insured By: Great-West Life & Annuity Insurance Company

ELIGIBILITY

The LowerMark Plus International Student's Medical Benefits Plan is designed for international and practical training students and their dependents. The Plan is available by virtue of a master accident & sickness insurance policy issued by the Company, Great-West Life & Annuity Insurance Company, to a university, college or other educational organization.

An "Eligible Student" means a student of the Policyholder who is engaged full-time in international educational activities, is temporarily outside the student's home country or country of regular domicile as a non-resident alien in the United States; and has a current passport or applicable student visa.

An "Eligible Dependent" means a dependent of an Eligible Student who has a current passport or visa; is temporarily outside the dependent's home country or country of regular domicile as a nonresident alien in the United States; is the Eligible Student's lawful spouse or unmarried Child (natural Child, step-Child, natural grandchild, adopted Child or Child Placed For Adoption under age 21 and dependent upon the Eligible Student or the student's spouse for the Child's main support and care); resides with the Eligible Student; and is enrolled for coverage under the policy at the same time the Eligible Student enrolls or within 31 days of first becoming eligible. Dependent children born in the United States and disabled, unmarried children age 21 and over (exceptions apply) are also Eligible Dependents.

COVERAGE PERIOD

Provided an Enrollment is properly completed and the correct premium is received timely, an Eligible Student or Eligible Dependent becomes an Insured Individual on the first day of the school term for which coverage is applied for or, if different, the effective date required by the Policyholder for all similarly situated eligible persons. Dependent coverage cannot become effective prior to the effective date of coverage of the Eligible Student.

Coverage will automatically terminate on the earliest of:

- A. The date the Policy terminates;
- B. The last day of the period for which premium has been timely paid according to Policy provisions;
- C. The date the Insured Individual is no longer eligible for coverage;
- D. The date requested by the Insured Individual approved by the Policyholder in writing that is no sooner than 5 days after the date the Company or its authorized administrator receives written notice; Any unearned premium will be returned, but returned premium will only be for the number of full months remaining in the unexpired term of coverage.
- E. The date the Insured Individual departs the United States for the Student's home country or country of regular domicile.

To avoid a break in coverage, (and another pre-existing condition limitation period), students should make sure coverage is in place and paid for when taking a term off from school, even if the student is leaving the country. Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from this Policy to group coverage provided under a qualified plan.

MEDICAL EXPENSE BENEFITS

Each Insured Student has a Medical Benefit maximum of \$250,000 per Accident or Sickness, but not exceeding \$250,000 for all Accidents and Sickness in any consecutive 12 month period.

Each Insured Dependent has a Medical Benefit maximum of \$50,000 per Accident or Sickness, but not exceeding \$50,000 for all Accidents and Sickness in any consecutive 12 month period.

Copayments and Coinsurance

A Copayment will be applied to Covered Expenses as follows:

1. For charges from a Physician, Covered Expenses will be paid at:
 - a. 100% without application of a Copayment for services provided to an Insured Student at a Student Health Center;
 - b. 100% after the Insured Individual pays a \$25 Copayment per visit for services provided by a Participating Provider;
 - c. 80% after the Insured Individual pays a \$25 Copayment per visit for services provided by a Physician who is not a Participating Provider.
2. For charges incurred at a Hospital (including inpatient and outpatient services), Covered Expenses will be paid at:
 - a. 100% after the Insured Individual pays a \$100 Copayment per admission for services provided by a Participating Provider;
 - b. 80%* after the Insured Individual pays a \$100 Copayment per admission for services provided by a Hospital which is not a Participating Provider.*100% if for Emergency Care, provided by a Non-Participating Provider Hospital, if it was not reasonably possible to get to a Participating Provider Hospital for emergency care.

Benefits will be paid at the levels described above unless stated otherwise.

“**Emergency Care**” means covered services required to screen and stabilize an Insured Individual within 48 hours after an accidental Injury or Emergency Medical Condition. Such condition is one that is sudden, unexpected and manifests itself by symptoms of sufficient severity to lead a prudent medical lay person to believe immediate medical care is required. Such conditions may include those placing the patient’s health in jeopardy; impairment of bodily functions; dysfunction of any bodily organ or part; uncontrolled pain; or pregnancy complications.

Out-of-Pocket Expense Maximum

When \$2,500 in Out-of-Pocket Expenses has been paid by an Insured Individual during a calendar year, the 80% level of benefit payments, if otherwise applicable, will automatically increase to 100% for additional Covered Expenses incurred by that Insured Individual during the remainder of that calendar year, and Copayment charges will no longer apply. An Out-of-Pocket Expense is the 20% share of any otherwise Covered Expense and Copayment amounts which an Insured Individual pays.

Medical Benefits

Subject to the exclusions, limitations, and all other provisions of the Policy, benefits are payable as stated above for a Covered Expense if: (1) the Copayment requirement is met; (2) the expense is incurred due to a covered Injury or Bodily Infirmary; and (3) the Insured Individual has not exceeded the Medical Benefit maximum for the Accident or

Sickness for which the expense is incurred, or for all Accidents or Sickness in any consecutive 12 month period. Covered Expenses under the Policy are limited to the following types of expenses prescribed by a Physician for therapeutic treatment of covered Injury or Bodily Infirmary when the fees for such are Reasonable and Customary:

- A. Charges for diagnosis and treatment by a Physician;
- B. Charges for daily Hospital room and board not exceeding the Hospital's Average Semiprivate Charge and Intensive Care Unit charges;
- C. Charges by a Hospital for medical care received on an outpatient basis and outpatient medical supplies used on the premises of a Hospital;
- D. Charges for laboratory, x-ray, and other diagnostic examinations;
- E. Charges for prescription drugs required to be dispensed by a licensed pharmacist, except the Policy will pay 100% of charges for such drugs used on an inpatient basis or dispensed by a Physician at a Student Health Center and 50% of charges for such drugs not dispensed by a Physician at a Student Health Center and used for outpatient treatment
- F. Charges for professional ambulance service by ground or air to a Hospital or neonatal special care unit, if the Insured Individual is a sick Child (see Medical Evacuation Benefit for air service to an Insured Individual's home country);
- G. Coverage will also include transportation by professional ambulance services for a temporarily medically disabled mother who has recently given birth to a sick newborn Child and is accompanying this Child to the nearest available Hospital or neonatal special care unit. The mother's need for transportation must be certified, by her attending Physician, that normal travel would be hazardous to her health.
- H. Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
 - (a) man-made limbs or eyes for the replacing of natural limbs or eyes;
 - (b) casts, splints or crutches;
 - (c) purchase of a truss or brace;
 - (d) oxygen and rental of equipment for giving oxygen;
 - (e) rental of a wheelchair or hospital bed;
 - (f) rental of dialysis equipment and supplies;
 - (g) colostomy bags and ureterostomy bags; and
 - (h) two external post-operative breast prostheses.The policy will not cover rental charges for equipment in excess of the purchase price of the equipment;
- I. Charges for home health care performed by a licensed home health agency when prescribed by a Physician in lieu of Hospital services, provided the Hospital services would have been Covered Expenses;
- J. Charges for one routine baseline or screening mammogram and one routine pap smear in any consecutive 12 month period for women age 18 and over, or more frequently based on a Physician's recommendation without application of the deductible;
- K. Charges for services of an interpreter for the hearing impaired in conjunction with eligible medical treatment or diagnostic consultations performed by a Doctor;
- L. Charges for hearing aids for Insured Individuals 18 years of age or younger provided the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist. Coverage is limited to one hearing aid in each ear every three years subject to a maximum benefit of \$1,400.00 per hearing aid;
- M. Charges for routine prostate preventive care, without application of the Deductible, for the detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, for men over the age of 50 years and for men over the age of 40 years, if Medically Necessary. Coverage is limited to one routine annual visit, provided that a second visit is allowed based upon a medical need and follow-up treatment

within 60 days after either visit, if related to a condition diagnosed or treated during the visits;

- N. Charges for anesthesia when rendered in a Hospital setting and for associated Hospital charges when the mental or physical condition of the Insured Individual requires dental treatment to be rendered in a Hospital setting;
- O. Child immunizations, including the immunizing agents, which, as determined by the State Health Office, conform with the complete basic immunization series for children up to the age of 6; and
- P. Expenses for Low Protein Food products for treatment of Inherited Metabolic Diseases as defined in the Inherited Metabolic Diseases provision subject to a maximum benefit of \$200 per month.

Physiotherapy Expenses

Covered Expenses for Physiotherapy (as defined below) which are incurred while not confined in a Hospital and which are billed by a Physician or physiotherapist are payable on the same basis as any Sickness.

“Physiotherapy” means treatment of Injury or Bodily Infirmary by the use of physical means including, but not limited to, air, heat, light, water, electricity, massage, manipulation, acupuncture or active exercise.

Pregnancy Benefits

Covered Expenses for pregnancy are payable the same as any other Covered Expenses for any other Bodily Infirmary with respect to an Insured Student or Covered Dependent spouse. No benefits are payable for any expense which relates to the pregnancy of a Dependent Child.

Pregnancy coverage also includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYNs.

Newborn Infants

A newborn Child of an Insured Student is eligible for coverage from the date of birth provided that (1) notice of the birth is provided to the Company or its authorized administrator within 31-days from the date of birth or released from a Hospital, whichever is earlier; and (2) premium for coverage from the date of birth is received. As an additional benefit, if (1) and (2) above are satisfied, the newborn Child will be covered for Hospital room and board (or nursery) charges, routine Physician hospital visits, and circumcision. This “well baby” coverage will terminate the earlier of the date the newborn is seven days old or the date the Child is discharged from the Hospital. If (1) and (2) above are not satisfied, a newborn Child of an Insured Individual will automatically be an Insured Individual only for Covered Expenses incurred which are due directly to Injury or Bodily Infirmary, premature birth, or a congenital condition which exists at birth. This coverage, including any continuation of benefits, will terminate 31 days after the date of birth.

Intercollegiate/Interscholastic Sports Benefit

Benefits will be payable up to a maximum benefit of \$5,000 per Accident arising out of practice for or participation in intercollegiate or interscholastic sports.

Post-Mastectomy Coverage

Coverage of a Medically Necessary mastectomy will also include coverage of the following:

1. physical complications during any stage of the mastectomy, including lymphedemas;

2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

Mental and Nervous Disorders/Substance Abuse (Other than Severe Mental Illness below)

Benefits will be paid for inpatient treatment of a Mental or Nervous Disorder or Substance Abuse up to an aggregate limit of 30 days of inpatient care in any consecutive 12-month period. Outpatient treatment will be paid subject to a maximum number of outpatient visits of 10 in any consecutive 12-month period.

Severe Mental Illness

Charges for psychiatric/psychological services for Severe Mental Illness are a Covered Expense subject to 45 days of inpatient treatment in any consecutive 12-month period payable at 100% after the Copayment; and 52 days of outpatient treatment in any consecutive 12-month period payable at 100% after the Copayment.

An Insured Individual may be allowed to exchange two days of partial hospitalization for each inpatient day of treatment or may be allowed to exchange one inpatient day of treatment for four outpatient visits or exchange four outpatient visits for one inpatient day of treatment.

Severe Mental Illness includes any of the following:

1. schizophrenia or schizoaffective disorder;
2. bipolar disorder;
3. pervasive developmental disorder or autism;
4. panic disorder;
5. obsessive-compulsive disorder;
6. major depressive disorder;
7. anorexia/bulimia;
8. Asperger's Disorder;
9. intermittent explosive disorder;
10. posttraumatic stress disorder;
11. psychosis NOS (not otherwise specified) when diagnosed in a child under seventeen years of age;
12. Rett's Disorder;
13. Tourette's Disorder

Treatment of Attention Deficit/Hyperactivity Disorder

Coverage for the diagnosis and treatment of attention deficit/hyperactivity disorder by an appropriate state licensed health care provider is considered a Covered Expense. Treatment must be rendered in the Doctor's office, a Hospital or a licensed public or private facility including but not limited to clinics and mobile screening units.

Benefits will be payable under the same terms and conditions as a physical Sickness but limited to \$600 for expenses incurred for the initial diagnosis. The maximum Covered Expense for professional services rendered during an outpatient visit will be \$50. Total benefits are subject to a calendar year maximum of \$2,500 and a lifetime maximum of \$10,000.

Diabetes Services and Supplies

Benefits are payable for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes, and non-insulin using diabetes when prescribed by a Physician as Medically Necessary. Benefits will be payable on the same basis as any Sickness.

Diabetes self-management training education will include a one time evaluation and training program, per Insured Individual, when determined to be Medically Necessary by a Physician. The evaluation and training program will be subject to a maximum of \$500 per Insured Individual.

Additional diabetes self-management training will be provided if Medically Necessary and prescribed by a Physician, in the event of a significant change in the Insured Individual's symptoms or conditions. This additional training is limited to \$100 per calendar year and a lifetime maximum of \$2,000 per Insured Individual.

A licensed health care professional, acting within the scope of his or her practice, must provide the diabetes self-management training.

Bone Mass Measurement (Osteoporosis)

Benefits will be payable same as any other Sickness for medically accepted bone mass measurement for a Qualified Individual for diagnosis and treatment of osteoporosis. A "Qualified Individual" means:

- a. an estrogen deficient woman at clinical risk of osteoporosis who is considering treatment;
- b. an individual receiving long term steroid therapy;
- c. an individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.

Clinical Trials for Cancer

Charges for the cost of investigational treatments and associated protocol related patient care resulting from treatment or studies provided in accordance with a clinical trial for cancer are a Covered Expense after satisfaction of the Copayment, if all of the following are met:

1. treatment is being provided or studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer for therapeutic or palliative reasons, or for the prevention of or early detection of cancer;
2. treatment is being provided in accordance with a clinical trial approved by: a) one of the United States National Institutes of Health; b) a cooperative group funded by one of the National Institutes of Health; c) the FDA in the form of an investigational new drug application; d) the United States Department of Veterans Affairs; e) the United States Department of Defense; f) a federally funded general clinical research center; or g) the Coalition of National Cancer Cooperative Groups;
3. the proposed protocol must have been reviewed and approved by a qualified institutional review board in Louisiana which has a multiple project assurance contract approved by the Office of Protection from Research risks;
4. treatment must be provided by health care providers acting within the scope of their practice, experience, and training with a volume of patients treated to maintain expertise;
5. clinical and pre-clinical data must provide a reasonable expectation that treatment will be at least as effective as the non-investigational alternative.

Cleft Lip and Cleft Palate Benefit

Services for the treatment and correction of cleft lip and cleft palate, in addition to benefits for secondary conditions and treatment attributable to the primary medical condition are considered a Covered Expense after satisfaction of the Copayment. Coverage includes, but is not limited to the following:

1. oral and facial surgery, surgical management, and follow-up care;
2. prosthetic treatment (i.e. obturators, speech appliances and feeding appliances);
3. orthodontic treatment and management;
4. preventive and restorative dentistry to insure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy;
5. speech-language evaluation and therapy;
6. audiological assessments and amplification devices;
7. otolaryngology treatment and management;
8. psychological assessment and counseling; and
9. genetic assessment and counseling for patient and parents.

Special Continuation for Surviving Spouses

If coverage on the Insured Student's surviving dependent spouse age 50 or over would terminate after the date of the Insured Student's death, such insurance may be continued after the date it would otherwise terminate, but not past the earliest of the following dates:

1. the date the Policy ends;
2. the date dependent coverage under the Policy ends;
3. as to any one Benefit, the date such Benefit ends, or the date the surviving spouse no longer qualifies for such Benefit;
4. the date the surviving spouse is eligible for coverage under Federal Medicare on another group health and accident plan;
5. the date the surviving spouse remarries;
6. the date the surviving spouse fails to make timely payment of the required premium.

The surviving spouse shall have 90 days after the date of the Insured Student's death to notify the Policyholder that the continuation option will be exercised. Coverage under the Policy will not be terminated during such period if the dependent spouse remains eligible for continuation of coverage.

Medical Evacuation Benefit

Subject to prior approval from the Company or its authorized administrator, as an additional benefit the policy will cover, up to a maximum benefit of \$50,000, charges for air evacuation of an injured or sick Insured Individual and a Health Care Provider or Escort, if directed by the attending Physician, to the individual's home country or country of regular domicile, provided air evacuation:

- (1) is upon the attending Physician's written certification; and
- (2) results from a covered Injury or Bodily Infirmity.

Repatriation Benefit

As an additional benefit, the policy will cover up to a maximum benefit of \$25,000 in the aggregate, reasonable expenses which are incurred in connection with the preparation and transportation of the body of a deceased Insured Individual to the individual's place of residence in the individual's home country. This benefit does not include transportation expenses of any person accompanying the body. Prior approval from the Company or its authorized administrator is required.

Continuation Benefits

Covered Expenses incurred, while Hospital confined, will be payable up to a maximum benefit of \$5,000 or 13 weeks, whichever comes first, for a covered Accident or Sickness for which an Insured Individual has a continuing claim on the date the individual's insurance terminates. Such benefits terminate if the Insured Individual becomes covered for the Accident or Sickness, for which benefits were continued, under any other medical coverage.

Coordination of Benefits

If the Insured Individual has other group type, governmental, or automobile no fault medical benefits coverage, the benefits payable under this policy will be coordinated with the other coverage so that the combined benefits paid or provided by all plans will not exceed 100% of the allowable expense. One plan will be determined to be primary under policy rules and its benefits will be payable first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

EXCEPTIONS AND EXCLUSIONS

The Policy will not cover charges or expenses:

1. for medical care, treatment, supplies, or services not listed in the types of Covered Expenses or identified in the policy as an additional benefit;
2. for medical care, treatment, supplies or services for the Insured Individual in his/her home country or country of regular domicile;
3. for elective or preventive surgery or medical care, services, supplies, or treatment including, but in no way limited to, tubal ligation, vasectomy, breast reduction or enlargement, correction or treatment of a deviated septum, abortion (except spontaneous and non-elective abortion), circumcision (except as covered under the Newborn Infants provision), learning disabilities, immunization, obesity, allergy tests, vitamins, and antitoxins;
4. for routine physical or health examinations, except if listed as a Covered Expense under the Medical Benefits section;
5. for any care in connection with the teeth, gums, jaw (except due to Injury resulting from an Accident), or structures directly supporting the teeth, myofacial pain, or temporomandibular joint dysfunction, except the policy will cover Injury to natural teeth resulting from an Accident, up to a maximum benefit of \$100 per tooth per Accident;
6. in excess of the Reasonable and Customary charge;
7. for cosmetic, plastic, reconstructive, or restorative surgery unless such Covered Expenses are incurred for repair of a disfigurement caused from: (a) an Injury; or (b) a birth defect of an insured Eligible Dependent born while the mother was insured under the Policy; or (c) a mastectomy (refer to the Post Mastectomy Coverage provision);
8. for medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
9. for hearing aids, eyeglasses, or contact lenses and the fitting or servicing thereof, except expenses for same resulting from a covered Injury or covered eye surgery;
10. for Injury or Bodily Infirmity if covered to any extent under any occupational benefit plan, Workers Compensation or similar law or medical payments under individual automobile insurance (except no-fault);
11. for birth control, including surgical procedures and devices;
12. for Injury arising out of practice for or participation in professional sports;
13. for medical care, treatment, services, and supplies for which no charge is made or for which no payment would be required if the Insured Individual did not have this insurance; unless furnished by a Hospital owned or operated by Louisiana or any of its political

- subdivisions, or to the extent the Insured Individual received any discount, credit, or reduction due to an agreement with the provider;
14. for intentionally self-inflicted Injury or Bodily Infirmary, suicide, or attempted suicide, while sane or insane; or Injury or Bodily Infirmary resulting from taking part in the commission of an assault or felony;
 15. for diagnosis, treatment and all other care related to infertility;
 16. for Injury arising out of aeronautics such as hang gliding, skydiving, parachuting, or air travel, except while riding as a passenger on a regularly scheduled commercial airline;
 17. resulting from a motor vehicle accident if an Insured Individual was operating the vehicle without a valid driver's license in the state where the Insured Individual primarily resides while attending school;
 18. for Injury or Bodily Infirmary resulting from an act of war (declared or undeclared), insurrection, participation in the military service of any country, or participation in a riot or civil disorder;
 19. for medical care, treatment, services, or supplies normally given without charge and provided by employees or Physicians employed by, under contract with, or retained by the Policyholder; and
 20. for medical care, treatment, services, or supplies for which benefits are excluded, excepted, or limited elsewhere in the Policy.

Pre-Existing Condition Limitations

The policy will not cover charges or expenses due to a pre-existing Injury or Bodily Infirmary or complication thereof. A pre-existing Injury or Bodily Infirmary is one where the Insured Individual has consulted a Physician; had medicine prescribed; or is receiving or has received medical care for that Injury or Bodily Infirmary in the 6 months prior to the Insured Individual's Effective Date of Coverage under the Policy.

However, after an Insured Individual's insurance has been in force for 12 consecutive months, Covered Expenses incurred after this 12 month period for a pre-existing Injury or Bodily Infirmary will be payable.

Modifications to Pre-Existing Limitations: The Pre-Existing Conditions Limitations provision is modified to provide credit toward satisfaction of the Pre-Existing Conditions Limitations period for the time covered under previous Creditable Coverage. Credit for previous Creditable Coverage will not be given if a period greater than 63 days (a Creditable Coverage) has occurred from the time the person was covered under previous Creditable Coverage until the Covered Person's Enrollment Date under the Plan. Time served during a waiting period does not count as a break in Creditable Coverage and does not count as Creditable Coverage.

The Policy will not impose pre-existing limitations on a Child who was covered by Creditable Coverage within 31 days of birth, adoption or Placement for Adoption, provided the Child has not subsequently been without Creditable Coverage for more than 63 days.

"Creditable Coverage" means any of the following coverage, obtained in the United States, that an Insured Individual had prior to enrollment under the Policy: an employee group health plan; health insurance coverage, individual or group, including coverage through a Health Maintenance Organization (HMO); Medicare; Medicaid; TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families; a medical care program of the Indian Health Service or of a tribal organization; a state health risk pool; a health plan offered under the Federal Employee Health Benefits Program; a public health plan established or maintained by a political subdivision of a state to provide

insurance coverage; a health benefit plan established by the Peace Corps Act; or a State Children's Health Insurance program (S-CHIP).

Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under this Policy to group coverage by another plan. Coverage provided by this Policy is not considered Creditable Coverage by this or other student health policies.

Days of Creditable Coverage that occur before a Significant Break in Coverage do not count towards satisfaction of the pre-existing limitation. A Significant Break in Coverage means a period greater than 63 days during all of which the individual does not have Creditable Coverage.

DEFINITIONS

“Accident” means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual and independent of any other such force or event.

“Average Semiprivate Charge” means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

“Bodily Infirmary” means a Medical Condition of an Insured Individual caused by, arising out of, resulting from or the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual.

“Copayment” means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion.

“Hospital” means only such a place which is lawfully operated and licensed as a hospital for the care and treatment of sick or injured individuals; has permanent and full-time care for bed patients; has a staff of one or more licensed physicians available at all times; provides 24-hour a day care by registered nurses on duty or call; has surgical facilities; and is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a hospital used as such.

Hospital also means an “Ambulatory Surgical Center” which is a licensed public or private place; has an organized medical staff of Physicians; has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; has RN services in the facility and does not provide services of beds for patients to stay overnight.

“Hospital Admission” means a single period of hospital confinement or outpatient care for one or more causes.

“Injury” means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual.

“Medical Condition” means any bodily or mental disease, illness or injury requiring treatment by a Physician.

“Medically Necessary” means any service or supply for diagnosis or treatment that is:

- a. Prescribed by a Doctor to be necessary and appropriate; and
- b. Non-experimental or non-investigational; and
- c. Not in conflict with accepted medical or surgical practices prevailing in the geographic area where, and at the time when, the service or supply is ordered.

“Mental or Nervous Disorder” means neurosis, psychoneurosis, psychosis, or mental disease or disorder of any kind resulting from any cause including, but in no way limited to, biological cause.

“Participating Provider” means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates.

“Physician or Doctor” means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a close relative of the Insured Individual, or residing at the same legal residence as the Insured Individual. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Medical Benefits are provided under the Policy.

“Placed For Adoption” means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of adoption. Placement is considered terminated upon termination of legal obligation.

“Reasonable and Customary” means, with regard to charges for medical services or supplies, the lowest of:

- a. the usual charge by the provider for the same or similar medical services or supplies;
- b. the usual charges of most providers of similar training and experience in the same or similar geographic ‘area’ for the same or similar service or supplies; or
- c. the actual charge for the services or supplies.

‘Area’ means the location where the medical care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of medical care or supplies.

“Sickness” means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from or the cause of One Period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. “One Period” commences with the onset of the initial (or only) Bodily Infirmary that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmary that occurred during that Sickness for ninety (90) consecutive days.

Prescription & Vision Discount Card

The prescription and vision discount cards are offered through Express Scripts, and provides a discount on many prescription drugs and eye care products. The discount program provides discounts at participating pharmacies and vision providers nationwide.

The discount card does not guarantee that a prescription will be covered. For prescription reimbursements, please complete a claim form and mail to the Lewer Agency for reimbursement. Mail completed form to:

The Lewer Agency, Inc.
P.O. Box 32247
Kansas City, MO 64171-5247

Participating vision providers can be located by visiting the Cole Managed Vision website: www.colemanagedvision.com/find or by calling at 1-800-804-4384 for Vision Plan #56003. Simply present the Express Scripts Prescription Drug Identification card and the student will automatically receive the discounted prices. There is no claim to file and no waiting for reimbursement.

24/7 Medical Help Line

This service provides the student with 24 hour telephone access to registered nurses. The nurses can provide the student with easy to understand information on a wide range of health issues. The toll free phone number is 800-872-1414. Multilingual providers are available on the Medical Help Line 24 hours a day, 7 days a week.

Global Emergency Medical Evacuation – Assist America

In the event that a student becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transportation necessary to evacuate a participant student to the nearest facility capable of providing appropriate care. With one phone call, Assist America's team of professionals will handle the transportation arrangements to a more suitable hospital.

Assist America's medical personnel will also maintain regular communication with the enrolled member's attending physician and/or hospital and relay any information to the participant's family.

For global emergency assistance call Assist America's toll free number, 800-872-1414.

Repatriation – Assist America

If a student requires medical assistance upon being discharged from a hospital, Assist America will repatriate him/her home or to a rehabilitation facility with a medical or non-medical escort, as necessary. In the event of death of a member participant, Assist America will render every possible assistance in returning the mortal remains including locating a funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. An Assist America card will be supplied to the student once the student has enrolled in the LewerMark Health Insurance Plan.

The Assist America card must be carried at all times. For global emergency assistance or when the insured student is 100 miles away from his/her primary residence a toll-free number is available, 800-872-1414.

Finding a PPO Network Provider – Great-West

By enrolling in this insurance program the insured member has the Great-West Healthcare Provider Network available for in-network medical services. The use of a provider in the Great-West Healthcare network may reduce the insured's out of pocket expenses, as network providers have negotiated to accept lower fees as payment for their services.

There are many doctors and hospitals available. Go to www.lewermark.com and click "Find a Doctor." Select Great-West Healthcare as the PPO network.

HIPAA

HIPAA Privacy: The Lewer Agency, Inc. and Great-West Life and Annuity Insurance Company value your privacy and have in place policies to protect your private health information. To view both of our HIPAA Privacy Policies, please see our website at www.LewerMark.com. To obtain a copy of either of these policies, please contact The Lewer Agency, Inc., Privacy Officer, 4534 Wornall Road, Kansas City, Missouri, 64111, (816) 753-4390 or (800) 821-7715.

NOTICE AND PROOF OF CLAIM

Written notice of any event that may lead to a claim under the policy must be given to the Company or its authorized administrator within 60 days after the event. When the Company or its authorized administrator receives a notice of claim, it will send the claimant forms for filing proof of claim. If the forms are not given to the claimant within 15 days, the claimant will meet the proof of claim requirements by giving the Company or its authorized agent a statement, in writing, of the nature and extent of the loss within the time required.

Written proof of loss must be furnished to the Company within 90 days after the date of loss. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

PAYMENT OF CLAIM

Benefits will be paid as soon as the Company or its authorized administrator receives satisfactory proof of loss. All benefits will be paid to the Insured Student subject to any written assignment of benefits by the Student that is authorized by and in accordance with the Policy. If an Insured Individual uses a Participating Provider, benefits, if any, may be paid to the provider of service.

IMPORTANT NOTICE

This brochure is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the Master Policy, the Master Policy will govern.

Any provision of the Master Policy in conflict with the laws of the jurisdiction in which the Policyholder is located is hereby automatically amended to conform to the minimum requirement of those laws.

The Policyholder requires its international and practical training students to carry medical insurance coverage. This coverage must be accepted by the student unless proof of other coverage (acceptable to the Company) is provided.

For information and assistance, call the Lewer Agency at: 1-800-821-7710.

Insured By:

Great-West Life & Annuity Insurance Company