



**Division of Finance
Purchasing**

ADDENDUM #1

May 15, 2026

RE: Sealed Bid Number 50012-653-26: International Student Health Insurance

The following information is provided to amend the original invitation to bid on April 24, 2026.

- **The solicitation allowed for vendors to submit questions and for the University to provide answers to these questions. This addendum was created to answer the questions received from vendors and to provide supplemental information provided by the University and its current provider.**

Due to the size and length of the Addendum, physical copies will not be mailed. Vendors can access the addendum on LAPAC at the following url.

<https://www.cfprd.doa.louisiana.gov/osp/lapac/dspBid.cfm?search=department&term=34>

Vendors are not required to acknowledge this addendum on their bid submission.

All other specifications remain unchanged.

Sincerely,

Clint Williams
Assistant Director of Purchasing
Louisiana Tech University
(318) 257-4205
clintw@latech.edu

International Student Health Insurance 50012-653-26

Questions received by prospective vendors regarding this solicitation. The University, along with its current provider, have provided the available information to the submitted questions below. Questions from prospective vendors are in **BLACK**, while answers / responses are in **RED**. ***Note: Questions are provided just as they were received from the vendors, with no edits or changes.***

1. Request for 3 years of loss runs
Please refer to Attachment C of the original sealed bid solicitation
2. Paid and incurred amounts
Please refer to Attachment #1 of Addendum #1 for details from 2023-2024 and 2024-2025. Information regarding 2025-2026 is not yet available.
3. Claim details and dates of loss
Please refer to Attachment #12 of Addendum #1 for further information.
4. Are you seeking separate dedicated plans for F1 students and J1 visa holders?
The requested plan will be the same for both F1 and J1 visa holders
5. Please share comprehensive claims/loss reports for the previous 3 years of plan usage at the school –
Please refer to Attachment #2 of Addendum #1 for details from 2023-2024 and 2024-2025. Information regarding 2025-2026 is not yet available.
6. Please share breakdown of your total insured students in the following age groups as well as expected breakdown per school for 2026-2027:
 - Under 25: 146
 - 25 – 29: 100
 - 30 – 64: 69We expect a similar trend for 2026-2027. Please refer to Attachment #6 of Addendum #1 for details.
7. How many students have previously waived and who is normally in charge of the waiver process?
2023 – Data is not available as the University's ERP has changed.
2024 – 15 students obtained approved waivers
2025 – 9 students obtained approved waivers
The numbers provided above do not include student athletes.

All waiver requests must receive approval from the Director of the Office of International Affairs.
8. Please provide the monthly rates for the past 3 plan years.
We do not charge our students monthly. They are charged per quarter (our academic term).
2025 – 2026: \$350.33
2024 – 2025: \$304.55
2023 – 2024: \$304.55

9. Can you please explain the difference between the enrollments numbers and the claimants numbers? One shows 319 and other shows 499...what would be the expected total for AY26/27?
Numbers for AY26/27 will be largely dependent upon the number of incoming students, which we do not have the ability to forecast accurately in this environment.
Fall 2025-2026 - 319
Fall 2024-2025 - 499

10. How are intercollegiate activities currently covered?
Athletics maintains a separate insurance policy specifically for athletes actively participating in their sports. The athletes participation in this policy is waived as they are covered by the policy maintained by Intercollegiate Athletics.

11. Is this an online group self-enrollment process or how is it currently being done?
Currently, the Office of International Student Affairs provides a spreadsheet of registered students (not including those that have an approved waiver) to our insurance broker. The broker then enrolls the students into their platform.

12. What is the waiver process and criteria?
Insurance will only be waived if the student meets the following criteria:

- they are a student athlete actively competing for Louisiana Tech University,
- they are on OPT and receive health insurance coverage by their employer,
- they have a spouse who is a permanent resident and receive coverage as a dependent of that spouse,
- they have parents who are permanent residents and receive coverage as a dependent.

Can you share the waiver acceptance rate year over year? How many students successfully waived out of the plan in AY26?

If the students meet one or more of these criteria, they then must provide proof of current insurance. It is only then that the student will be waived. We don't have official records of the amount of waiver requests submitted, so we are unable to provide an acceptance rate. Please see the response for Question #7 for actual numbers of students that have waivers that were approved. As of May 14, 2026, 2 students have been waived from insurance requirements for the 2026-2027 academic year.

13. What has the premium trend looked like over the past 3 years — have rates remained flat, increased, or decreased at renewal? If increases occur, what was the primary driver cited by the current broker/carrier?
Rates remained the same for two (2) years. The third year they were increased by referencing PwC inflation, which is the language in the bid.

14. Please provide a copy of the 25/26 insurance policy.
Please refer to Attachment #3 for Addendum #1 for this information

15. Should dental and vision coverage be offered to students on a voluntary basis, or be automatically included in the insurance policy.
The students have elected to have these as part of the overall plan. So, we would like this automatically included.
- a. If automatically included, should the premiums for dental and vision be broken down into specific line items?
These items need to be included in the overall premium as that matches the bidding form.
16. The RFP states that the policy should have no more than a \$300 deductible. Does Louisiana Tech want to see other deductible options, or should respondents present only options that represent the lowest premium?
\$300 is our maximum deductible.
17. Please provide current plan premium, and premiums for the 24/25 and 23/24 premiums.
Please refer to Question #8 for this information.
- a. Does the school include an administrative fee within the premiums?
The University does not add an administrative fee.
18. Please provide plan brochures for previous three years.
Please refer to Addendum #1 Attachment #7 for this information.
19. Please provide number of students enrolled in the health plan during the 23/24 and 24/25 plan years.
2023-2024 – 303
2024-2025 – 473
2025-2026 – 445
20. Please provide the number of high-cost claimants (claims over \$25,000) for the current policy year, 24/25 and 23/24.
2023-2024 – 3
2024-2025 – 2
2025-2026 – 2 (as of 5-14-2026. Our academic year is still currently active)
21. Please confirm if the claims detail provided is summarize dbase don paid date or incurred date? If incurred date please provide the paid through date.
Cigna is based on paid date, and while Wellfleet is paid on incurred date.
22. Please confirm if there have been any plan changes during the experience period. If so please detail them changes and their effective dates.
In year 1 and 2, we had the same premium, coverage and provider. In year 3, rates were raised due to inflation utilizing PwC and we switched to Cigna's network.

Policy Changes from 2024/2025 to 2025/2026 (Wellfleet to Cigna):

- Copay changes:
 - IP Hospital from \$50 to \$200
 - ER from \$150 to \$350
 - OV copay from \$25 to \$40
- Pre-Existing Conditions: 6 month waiting period to No waiting period
- Wellness/Preventive from \$250 to \$0
- Mental Health
 - Out-Patient from no limit on # of visits to 10 visits maximum
 - IP from no limit on # of days to 30 days maximum
- Out-Patient Physiotherapy from no limit on # of visits to 20 visits maximum
- Out-Patient Rx from 75% coinsurance to copays of \$20/\$50/\$75 depending on tier 1-3

- Dental Injury from unlimited to \$1,000

EXCLUSIONS: Please refer to the list of exclusions in the certificates. Please note that Cigna does not exclude:

- Pre-Existing Conditions
- Transplants
- Home Country
- Hazardous Sports and Activities
- Organized Sports

23. Please provide Premium Lives covered and claims by month for each experience period

The University was not provided a definition of 'Premium Lives', therefore we are not able to provide information on this question.

24. Please provide high dollar claims details in excess of \$50,000 for each experience period with diagnosis, prognosis and claimant status.

No high dollar claims for current year.

Please refer to Addendum #1 Attachment #8 for this information

25. Detailed claims reports

Please refer to Addendum #1 Attachment #9 for this information

26. Current policy / plan design

Please refer to Question #14 for this information.

Please refer to Addendum #1 Attachment #3 for this information

27. Historical premium rates:

Please refer to Question #8 for this information.

28. Please provide a copy of the current policy and the Wellfleet policy. If the Wellfleet policy is not available, please identify any major plan discrepancies.

Please refer to Addendum #1 Attachment #10 for this information

29. Please provide the current brochure and brochures for the previous three (3) plan years

Please refer to Addendum #1 Attachment #7 for this information

30. Please provide the current master policy/certificate and the master policies/certificates for the previous three (3) plan years, if available.

Please refer to Addendum #1 Attachment #10 for this information

31. Please provide the current rate and rate history for the previous three (3) plan years.

Please see Question #8 for this information.

32. Please provide total premium, headcount, and loss history for the current year and previous three(3) plan years.

Total gross premium collected by year:

- 2023/2024: \$320,260.49
- 2024/2025: \$454,409.92
- 2025/2026: \$416,305.63

33. Are premium, headcount, and loss history available for 2021 and 2022?

Please refer to Addendum #1 Attachment #11 for this information

34. Please provide detailed claims reporting for the current year and previous three (3) plan years, including:
- a. Total paid claims
 - b. Medical paid claims
 - c. Rx paid claims
 - d. Large claims

Please refer to Addendum #1 Attachment #9 for this information

35. Please provide updated losses and claims data for the past three (3) or more years, if available.

Please refer to Addendum Attachment #9 for this information

36. What provider network was used in 2023 and 2024?

Cigna PPO.

37. Are there any plan changes Louisiana Tech University would like to see for the upcoming policy year?

Please refer to the original bid specifications.

38. Please confirm the broker commission to include in the proposal.

Yes, it is included in the rates.

39. The RFP requires Northern Louisiana Medical Center and Allegiance Medical Clinic to be included as in network providers. Please provide the TIN(s), NPI(s), and legal entity names associated with each facility to allow for accurate network validation.

TIN Hospital: 844422249 and Medical Clinic is the same.

NPI: Hospital: 1962024026 Clinic: 1245964931

Legal Entity Names: Unknown

40. The RFP indicates that services referred by the on-campus Student Health Center receive reduced cost sharing. Please clarify:

Are there specific providers or facilities that SHC referrals are intended to direct students to?

Is there any additional tiering beyond what is listed in the benefit schedule?

The clinic on campus is currently managed by Allegiance. They tend to refer students to the North Louisiana Medical Center as it is also an Allegiance managed facility.

Is there a penalty, higher cost share, or benefit reduction if services are accessed without an SHC referral?

The reference to the Student Health Center should be understood to mean the University's on-campus clinic, currently operated by Allegiance. The intent of this provision is to encourage appropriate use of the on-campus clinic as the first point of care for non-emergency medical needs and to reduce unnecessary use of hospital or emergency services. Services provided at the on-campus clinic are intended to be available at \$0 copay and without application of the deductible. Referrals from the on-campus clinic are generally expected to be directed to appropriate in-network providers or facilities, including but not limited to North Louisiana Medical Center and Allegiance-affiliated providers when medically appropriate. The University is not establishing a separate closed referral network through this provision. There is no intended penalty, benefit reduction, or denial of coverage solely because a student accesses covered services without an on-campus clinic referral. In that case, the applicable plan deductible, copayment, coinsurance, network provisions, and other policy terms would apply. Any reduced cost-sharing available for on-campus clinic referrals should be clearly described in the bidder's response, including whether the reduction applies to copayments, deductibles, coinsurance, or specified services only.

41. If there are specific referral providers, please provide the provider's name(s), TIN(s), and NPI(s).

Please see Question #40 for this information.

42. Please provide rates net of broker fees for the current year and previous three plan years, if available.

Net rates are unavailable, please refer to Question 8 for gross rates.

43. Attachment C lists Top Providers by utilization. Please provide the TIN(s), NPI(s), and legal entity names for the providers listed to ensure accurate validation of network participation.

Please see Question #39 for this information.

44. Please describe how the University's Student Health Center (SHC) is currently reimbursed under the student health insurance program and the expectations for the proposed plan, including:

Whether the SHC is reimbursed based on:

A participating provider contract within the medical network,

An approved fee schedule, or

Another reimbursement methodology (please describe).

Whether the expectation is for the SHC to:

Participate in the carrier's provider network, or

Reimburse services based on a set or negotiated fee schedule outside of the standard network structure.

Tech Care, which serves as the Louisiana Tech Student Health Center, is in network with Cigna. Eligible expenses are reimbursed at 100% and are not subject to the deductible. This is the University's expectation for reimbursement at the Student Health Center.

45. Please confirm whether Louisiana Tech University has: An on-campus Student Health Center pharmacy, and/or A separate on campus retail pharmacy.

The University does not have a Student Health Center Pharmacy or a campus retail pharmacy.

46. Dental Policy/Benefits: The current plan is limited to injury only. Does the school intend for us to match their current plan, or would the school like to see a stand-alone dental policy?

We require standard dental and vision coverage to be automatically included in the overall policy. Please refer to Question #15

47. Please provide rates net of broker fees (current year and previous 3 years):

Net rates are unavailable, please refer to Question 8 for gross rates.

48. Are there any exception reports or benefits covered that are not listed in the certificate?

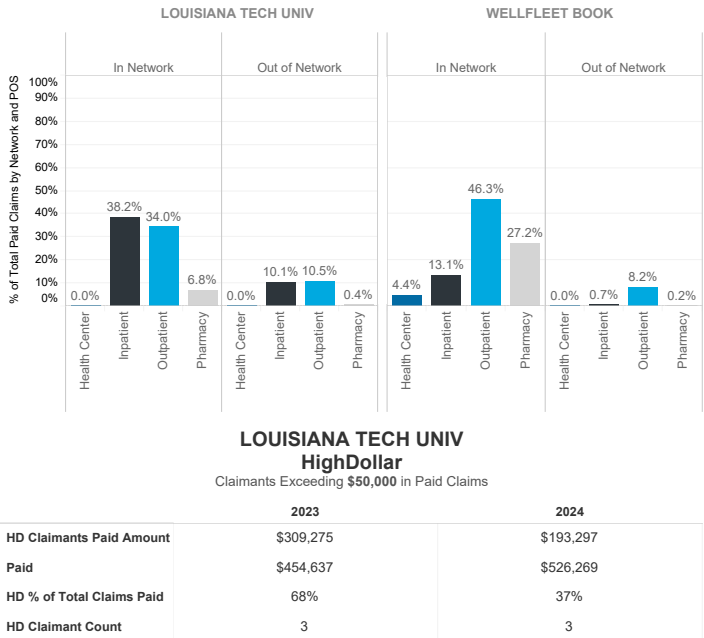
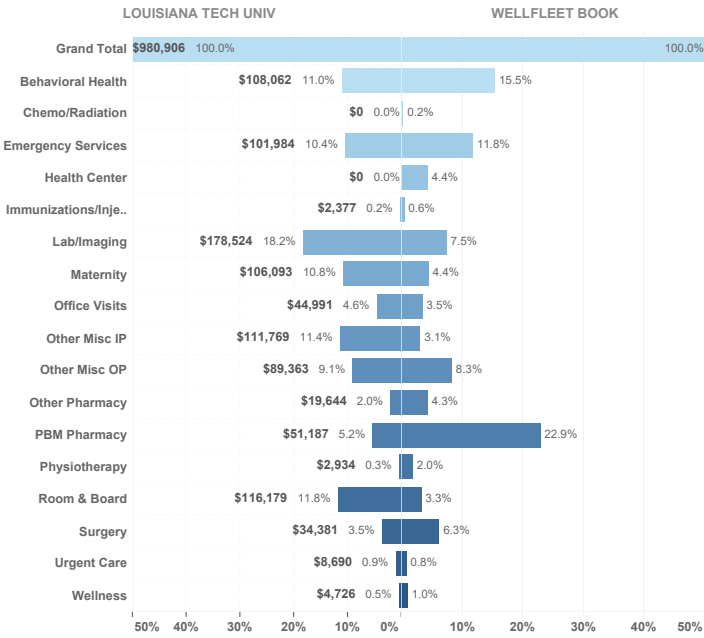
No.

49. Please provide all other vendor questions submitted and the University's corresponding responses.

Questions submitted by potential vendors shall be provided publicly as a published addendum. Potential vendors are not identified in this process, and vendors who submitted questions will be provided with an electronic version of this published addendum.

Addendum #1 - Attachment #1

Bid Number:	50012-563-26	Bid Title:	International Student Health Insurance



Based on policy respective start dates, paid through 4/30/2026
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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	Plan Year All	Report Type Life to Date	Provider All	Utilization Metric All	NetworkStatus All		All	Division All	Age Bracket

LOUISIANA TECH UNIV					
		Paid Claims Amount		% of Total Paid	
		2023	2024	2023	2024
	Unclassified	\$23,767	\$16,875	5.23%	3.21%
	Rx	\$5,131	\$46,056	1.13%	8.75%
A00 - B99	Infectious and parasitic diseases	\$3,136	\$9,700	0.69%	1.84%
C00 - D49	Neoplasms	\$483	\$99	0.11%	0.02%
D50 - D89	Blood and immune diseases	\$346	\$1,997	0.08%	0.38%
E00 - E90	Endocrine, nutritional and metabolic diseases	\$1,882	\$16,282	0.41%	3.09%
F01 - F99	Mental and behavioral disorders	\$107,520	\$2,331	23.65%	0.44%
G00 - G99	Diseases of the nervous system	\$1,013	\$14,889	0.22%	2.83%
H00 - H59	Diseases of the eye and adnexa	\$31,197	\$4,737	6.86%	0.90%
H60 - H95	Diseases of the ear and mastoid process	\$1,332	\$1,207	0.29%	0.23%
I00 - I99	Diseases of the circulatory system	\$4,340	\$6,768	0.95%	1.29%
J00 - J99	Diseases of the respiratory system	\$6,143	\$7,262	1.35%	1.38%
K00 - K99	Diseases of the digestive system	\$134,666	\$13,370	29.62%	2.54%
L00 - L99	Diseases of the skin and subcutaneous tissue	\$1,763	\$13,667	0.39%	2.60%
M00 - M99	Diseases of the musculoskeletal system and...	\$3,530	\$17,359	0.78%	3.30%
N00 - N99	Diseases of the genitourinary system	\$1,345	\$13,611	0.30%	2.59%
O00 - O9A	Pregnancy, childbirth and the puerperium	\$36,445	\$18,592	8.02%	3.53%
P00 - P96	Certain conditions originating in the perinatal...	\$198	\$2,236	0.04%	0.42%
Q00 - Q99	Congenital malformations, deformations and...	\$0	\$0	0.00%	0.00%
R00 - R99	Symptoms, signs and abnormal clinical and l...	\$59,243	\$84,496	13.03%	16.06%
S00 - T98	Injury, poisoning and certain other consequ...	\$4,605	\$122,669	1.01%	23.31%
V00 - Y99	External causes of morbidity	\$0	\$1,091	0.00%	0.21%
Z00 - Z99	Factors influencing health status and contact...	\$26,554	\$110,975	5.84%	21.09%
Grand Total		\$454,637	\$526,269	100.00%	100.00%

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Addendum #1 - Attachment #2

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	All	Plan Year	Report Type Life to Date	All	Utilization Metric	All	NetworkStatus	All	Division

LOUISIANA TECH UNIV

	Paid Claims Amount		Paid Claims Change %		Paid Claims Per Member		Paid Claims Per Member Change %	
	2023	2024	2023	2024	2023	2024	2023	2024
Health Center	\$0	\$0			\$0	\$0		
Behavioral Health	\$107,520	\$542		-99%	\$411	\$1		-100%
Lab/Imaging	\$46,327	\$132,198		185%	\$177	\$356		101%
Surgery	\$5,663	\$28,718		407%	\$22	\$77		257%
Emergency Services	\$39,851	\$62,133		56%	\$153	\$167		10%
All Other Inpatient	\$185,403	\$133,419		-28%	\$710	\$360		-49%
All Other Outpatient	\$57,189	\$111,111		94%	\$219	\$300		37%
Pharmacy	\$12,684	\$58,147		358%	\$49	\$157		223%
Grand Total	\$454,637	\$526,269		16%	\$1,740	\$1,419		-18%

Average Daily Membership

	ADM	% Change
Average Daily Membership 2023:	261.3	
Average Daily Membership 2024:	371.0	42.0%

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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Comparison	Medical Cost Per Member	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	All	Plan Year	Report Type Life to Date	Display Metric Claimants	Utilization Metric All	NetworkStatus All		Division All	Age Bracket All

LOUISIANA TECH UNIV									
		Claimant Count		Paid Claims Amount		Paid Claim by Claimant LTD		% of Plan Payments	
		2023	2024	2023	2024	2023	2024	2023	2024
Health Center	Health Center	0	0	\$0	\$0			0.00%	0.00%
	Category Total	0	0	\$0	\$0			0.00%	0.00%
Inpatient	Behavioral Health	1	0	\$106,688	\$0	\$106,688		23.47%	0.00%
	Lab/Imaging	2	4	\$19,010	\$8,756	\$9,505	\$2,189	4.18%	1.66%
	Maternity	5	2	\$37,526	\$53,348	\$7,505	\$26,674	8.25%	10.14%
	Other Misc IP	5	6	\$73,479	\$38,291	\$14,696	\$6,382	16.16%	7.28%
	Room & Board	2	4	\$74,398	\$41,781	\$37,199	\$10,445	16.36%	7.94%
	Surgery	1	3	\$5,288	\$15,259	\$5,288	\$5,086	1.16%	2.90%
	Category Total	16	19	\$316,389	\$157,433	\$19,774	\$8,286	69.59%	29.92%
Outpatient	Behavioral Health	2	6	\$832	\$542	\$416	\$90	0.18%	0.10%
	Chemo/Radiation	0	0	\$0	\$0			0.00%	0.00%
	Emergency Ser...	14	30	\$39,851	\$62,133	\$2,846	\$2,071	8.77%	11.81%
	Immunizations/I...	7	4	\$2,211	\$166	\$316	\$41	0.49%	0.03%
	Lab/Imaging	70	130	\$27,317	\$123,442	\$390	\$950	6.01%	23.46%
	Maternity	3	3	\$6,117	\$9,103	\$2,039	\$3,034	1.35%	1.73%
	Office Visits	111	197	\$15,050	\$29,941	\$136	\$152	3.31%	5.69%
	Other Misc OP	40	69	\$30,161	\$59,201	\$754	\$858	6.63%	11.25%
	Physiotherapy	2	4	\$270	\$2,665	\$135	\$666	0.06%	0.51%
	Surgery	25	41	\$375	\$13,460	\$15	\$328	0.08%	2.56%
	Urgent Care	14	37	\$1,570	\$7,120	\$112	\$192	0.35%	1.35%
	Wellness	15	38	\$1,811	\$2,915	\$121	\$77	0.40%	0.55%
	Category Total	303	559	\$125,564	\$310,688	\$414	\$556	27.62%	59.04%
Pharmacy	Other Pharmacy	18	31	\$7,553	\$12,091	\$420	\$390	1.66%	2.30%
	PBM Pharmacy	75	138	\$5,131	\$46,056	\$68	\$334	1.13%	8.75%
	Category Total	93	169	\$12,684	\$58,147	\$136	\$344	2.79%	11.05%
Grand Total		406	742	\$454,637	\$526,269	\$1,120	\$709	100.00%	100.00%

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H00 - H59	Diseases of the eye and adnexa	\$31,197	\$4,737	6.86%	0.90%
H60 - H95	Diseases of the ear and mastoid process	\$1,332	\$1,207	0.29%	0.23%
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O00 - O9A	Pregnancy, childbirth and the puerperium	\$36,445	\$18,592	8.02%	3.53%
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Q00 - Q99	Congenital malformations, deformations and ...	\$0	\$0	0.00%	0.00%
R00 - R99	Symptoms, signs and abnormal clinical and l...	\$59,243	\$84,496	13.03%	16.06%
S00 - T98	Injury, poisoning and certain other consequ...	\$4,605	\$122,669	1.01%	23.31%
V00 - Y99	External causes of morbidity	\$0	\$1,091	0.00%	0.21%
Z00 - Z99	Factors influencing health status and contact...	\$26,554	\$110,975	5.84%	21.09%
Grand Total		\$454,637	\$526,269	100.00%	100.00%

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Addendum #1 - Attachment #3

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance



Cigna StudyWell®

Summary of Benefits for:
Louisiana Tech University
Policy Number: 10676A

Global Health Benefits

All sources and disclosures are at the end of this document.
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Offered by Cigna Health and Life Insurance Company or its affiliates.



Insured and/or administered by:
Cigna Global Insurance Company Limited

Louisiana Tech University
Benefits at a Glance
Global Plan for all covered Members
Policy # 10676A
Plan Start Date September 1, 2025

This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

Cigna Healthcare, Global Health Benefits Customer Service		
Toll Free Telephone Number:	1.800.441.2668	
Direct Telephone:	1.302.797.3100 (collect calls accepted)	
Toll Free Fax Number:	1.800.243.6998	
Direct Fax Number:	001.302.797.3150	
Secure Website:	www.CignaEnvoy.com Registration is required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Healthcare P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Healthcare 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Annual Maximum	\$250,000		
Policy Year Deductible · Per Individual	\$0	\$200	\$400
· Per Family	\$0	\$400	\$800
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	75%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual	\$0	\$5,000	\$7,500
· Per Family	\$0	\$10,000	\$20,000



Global Medical Plan

Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit · Surgery Performed In the Physician's Office	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Student Health Center (if applicable)	Not Covered	100% not subject to deductible	100% not subject to deductible
Preventive Care · Routine Preventive Care · Policy Year Maximum: · Immunizations	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
Travel Immunizations (Immunizations as required for travel)	Not Covered	Not Covered	Not Covered
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	Not Covered	Not Covered	Not Covered
Inpatient Hospital · Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate) · Inpatient Hospital Physician Visits/Consultations · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% 100% 100%	\$200 copay, then 100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Services · Outpatient Facility Services · Outpatient Professional Services	100% 100%	100% after deductible 100% after deductible	75% after deductible 75% after deductible
Emergency Room	100%	\$350 per visit copay, then 100% not subject to deductible	\$350 per visit copay, then 100% not subject to deductible
Urgent Care Services	100%	\$50 copay, then 100% not subject to deductible	75% after deductible
Ambulance	100%	100% after deductible	75% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Laboratory Services · Physician Office Visit · Outpatient Facility · Laboratory Services at an Independent Lab facility	100% 100% 100%	100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Radiology Services · Physician Office Visit · Outpatient Facility	100% 100%	100% not subject to deductible 100% after deductible	75% after deductible 75% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) · Physician Office Visit · Inpatient Facility · Outpatient Facility	100% 100% 100%	\$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Therapy Services · Physician Office Visit · Outpatient Hospital Facility	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Policy Year Maximum:	20 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational, Cognitive, and Physical Therapy / Physiotherapy.			



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Chiropractic Care Policy Year Maximum:	Not Covered	Not Covered	Not Covered
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	100% after deductible	75% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· Delivery – Facility			
· Inpatient Hospital	100%	\$200 copay, then 100% not subject to deductible	75% after deductible
· Birthing Center	100%	\$200 copay, then 100% not subject to deductible	75% after deductible



Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Infertility, Fertility and Conception Services - Physician Office Visit and Counseling - Lab and Radiology Tests - Inpatient Facility - Outpatient Facility	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered
Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Device / Aids	Not Covered	Not Covered	Not Covered
Dental Care Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth - Physician Office Visit - Inpatient Facility - Outpatient Facility Policy Year Maximum	100% 100% 100%	\$40 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible 100% after deductible \$1,000	75% after deductible 75% after deductible 75% after deductible
Mental Health - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder) - Inpatient Facility Maximum: (combined with Substance Use Disorder)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible
Substance Use Disorder - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health) - Inpatient Facility Maximum: (combined with Mental Health)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay, then 100% not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible

Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	No Charge, not subject to plan deductible	
Purchased Inside the United States Only		
Benefit Highlights	Network Pharmacy (U.S. In-Network)	Non-Network Pharmacy (U.S. Out-of-Network)
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$20 copay	You pay 25% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$50 copay	You pay 25% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$75 copay	You pay 25% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$60 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$150 copay	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$225 copay	In-Network coverage only



Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Performance 3-Tier
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
Utilization Management	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Legacy 3-Tier"	

Global Evacuation Plan	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses for approved services.
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of Other
Return of Dependent Children	One-way Airfare at Economy Rates to return dependent children to country of residence
Repatriation of Mortal Remains	100% coverage



Global Telehealth

Teladoc Health International	Global telehealth gives you no cost 24/7 access to licensed doctors for non-emergency health issues. Common outreaches include fever, rash, pain, non-emergency pediatric care, and more. Referrals to specialists and prescriptions available when medically necessary and locally permitted. Telephone or video consultations can be arranged through Cigna Envoy (cignaenvoy.com).

Global Accidental Death & Dismemberment

Member Benefit	A flat benefit amount of \$10,000
Reduction of Benefits	To 65% at age 65 and 50% at age 70; Terminate at Retirement
Scope of Coverage	24 Hour Coverage

The information herein is believed accurate as of the date of publication and is subject to change. This material is intended for informational purposes only and contains only a partial and general description of benefits. Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Cigna Life Insurance Company of Canada, Cigna Global Insurance Company Limited, Evernorth Care Solutions, Inc., and Evernorth Behavioral Health, Inc. The Cigna Healthcare name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc., licensed for use by The Cigna Group and its operating subsidiaries. "Cigna Healthcare" refers to The Cigna Group and/or its subsidiaries and affiliates. Please consult your policy/customer certificate for a complete description of coverage and exclusions. In the event of a conflict or discrepancy, the terms of the formal plan documents control. Please contact your Plan Administrator for a copy of the plan documents. Coverage and benefits are contingent upon the applicable policy terms and are available except where prohibited by applicable law.



We're here for you, anytime you need us, 24/7/365 customer service

Cigna HealthcareSM, Global Health Benefits delivers world-class customer service and support to our clients and their globally mobile employees – at every stage of a global assignment. It does not matter where our clients or customers are working or what time zone – our global service center is open 24 hours a day, seven days a week. You can also contact Cigna Healthcare through the secure mailbox in [Cigna Envoy](#)[®].*

Contact us options

Toll-free telephone number	+1.800.441.2668
Toll-free TDD telephone number (for the hearing impaired)	+1.800.558.3604
Direct phone (collect calls accepted)	+1.302.746.3059
Toll-free facsimile number	+1.800.243.6998
Direct facsimile number (inside the U.S.)	+1.302.797.3150
Website	CignaEnvoy.com

Global Health Benefits



*Web-based tools, such as Cigna Envoy[®] are available for informational purposes only. These tools are not intended to be a substitute for medical care provided by a physician. The listing of a health care professional or facility in the mobile directories available through the Cigna Envoy mobile app does not guarantee that the services rendered by that professional or facility are covered under your benefits plan. Refer to your plan documents, or call the number listed on your ID card, for information about the services covered under your plan benefits. References to non-partnered organizations or companies, and/or their products, processes or services, do not necessarily constitute an endorsement or warranty thereof.

Product availability may vary by location and plan type and is subject to change. Products may not be available in all jurisdictions and are excluded where prohibited by law. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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Participating Sponsor/Group:
Louisiana Tech University

MEDICAL BENEFITS (OPEN ACCESS
PLUS)
EMERGENCY MEDICAL EVACUATION
AND REPATRIATION BENEFITS

EFFECTIVE DATE: September 1, 2025

CN001
10676A
1770096

This document printed in November, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your group or Cigna.

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*Address: P.O. Box 155
Mill Court
La Charroterie
St Peter Port Guernsey GY1 4ET*

CIGNA GLOBAL INSURANCE COMPANY LIMITED

(herein called Cigna) certifies that it insures certain Members for the benefits provided by the following policy(s):

POLICYHOLDER: CIGNA GLOBAL WELLBEING SOLUTIONS LIMITED

PARTICIPATING SPONSOR/GROUP: Louisiana Tech University

GROUP POLICY(S) — COVERAGE

10676A – MEDICAL BENEFITS (OPEN ACCESS PLUS)

10676A – EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS

EFFECTIVE DATE: September 1, 2025

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

All benefits payable under this Policy will be made in United States Dollars.

A handwritten signature in black ink, appearing to read 'Jae Lay', with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.



Special Plan Provisions

When you select a Participating Provider, the cost for medical services provided will be less than when you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. For a list of Participating Providers in your area, visit www.cignaenvoy.com or contact customer service at the phone number listed on the back of your ID card. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction with Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card. In addition, the Group, a claim

office or a utilization review program (see the Pre-Admission Certification (PAC)/Continued Stay Review (CSR) section of your certificate) may refer an individual for Case Management.

- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent are contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well-being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact us for details regarding any such arrangements.



Important Information

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility.
- pregnant and undergoing treatment for the pregnancy from the provider or facility.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If applicable, Cigna will notify you of your continuity of care options.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, pharmacies, and dental practitioners affiliated or contracted with Cigna or an organization contracting on its behalf.

How To File Your Claim

There's no paperwork for In-Network care. Just show your ID card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network and International claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms at www.cignaenvoy.com.

CLAIM REMINDERS

- BE SURE TO USE YOUR ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR ID CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network and International Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for Out-of-Network benefits or for International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for Out-of-Network benefits or for International benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Members as determined by the Group;
- you pay any required contribution; and
- you're traveling outside your country of residence for study abroad program

If you were previously insured and your insurance ceased, you must satisfy the New Member Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Members, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Members within one year after your insurance ceased.

Initial Member Group: You are in the Initial Member Group if you are employed in a class of Members on the date that class of Members becomes a Class of Eligible Members as determined by the Group.

New Member Group: You are in the New Member Group if you are not in the Initial Member Group.



Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of;

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Member Group: A period of time as determined by the Group.

New Member Group: A period of time as determined by the Group.

Classes of Eligible Members

- Students: each member identified as a student by the Participating Group.

Persons for whom coverage is prohibited under applicable law or sanction rules will not be considered eligible under this plan.

Effective Date of Member Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date when you become eligible for Member Insurance and your Dependent(s) become eligible for Dependent Insurance and when you elect it by signing an approved payroll deduction or enrollment form, as applicable.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Important Information About Your Medical Plan U.S.

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care inside the United States (in-network and out-of-network) and internationally (outside the United States). To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance, if any.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your ID card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that plan year.

Contract Year

Contract Year means a twelve month period beginning on each 09/01.

Out-of-Pocket-Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100% for the rest of that plan year.

- Coinsurance, if any
- Plan Deductible
- Copayments
- Prescription Drug Copayments and Coinsurance, if any

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties
- Provider charges in excess of the Maximum Reimbursable Charge



Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate between In-Network, Out-of-Network and International. All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In-Network, Out-of-Network and International unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in a payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Lifetime Maximum	Unlimited		
Annual Maximum	\$250,000		
The Percentage of Covered Expenses the Plan Pays See Definitions section for an explanation of Maximum Reimbursable Charge	100%	75% of the Maximum Reimbursable Charge	100% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Contract Year Deductible Individual Family Family Calculation Individual Calculation Family members must meet only their individual Deductible and then their claims will be covered under the plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the plan Coinsurance.	\$200 per person \$400 per family	\$400 per person \$800 per family	\$0 per person \$0 per family
Combined Medical/Pharmacy Contract Year Deductible	No	Yes	No
Contract Year Out-of-Pocket Maximum Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members must meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$5,000 per person \$10,000 per family	\$7,500 per person \$20,000 per family	\$0 per person \$0 per family
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Emergency Medical Evacuation & Repatriation Benefit Maximum: \$100,000			
Emergency Medical Evacuation	100%	100%	100%
Repatriation Following a Medical Evacuation	100%	100%	100%
Primary Repatriation to the Permanent Residence after a Serious Medical Event	100%	100%	100%
Repatriation of Mortal Remains	100%	100%	100%
Emergency Family Travel Arrangements and Confinement Visitation	100%	100%	100%
Return of Dependent Children	100%	100%	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Physician's Services			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Consultant and Referral Physician's Services	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Surgery Performed In the Physician's Office			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Second Opinion Consultations (provided on a voluntary basis)			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Allergy Treatment/Injections			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Student Health Center	100%	100% of the Maximum Reimbursable Charge	Not Covered
Inpatient Hospital - Facility Services	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate. (Private room covered outside the United States only if no semi-private room equivalent is available).
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Hospital Physician's Visits/Consultations	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Inpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Ambulance	Plan Deductible, then 100%	Plan Deductible, then 100% of the Maximum Reimbursable Charge	100%
Laboratory Services			
Physician Office Visit	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Laboratory Services at an Independent Lab facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiology Services			
Physician Office Visit	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Radiological Imaging (i.e. , MRIs, MRAs, CAT Scans and PET Scans) The scan Copay applies per day Physician Office Visit Inpatient Facility Outpatient Facility	\$200 scan Copay, then 100% \$200 per admission Copay, then 100% \$200 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%
Outpatient Therapy Services Physician Office Visit Outpatient Hospital Facility Contract Year Maximum: 20 days for all therapies combined Includes: Cardiac Rehab Physical / Physio Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Applied Behavior Analysis (ABA Therapy) Combined Contract Year Maximum: 30 days	\$40 per visit Copay, then 100% \$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene Therapy is only covered in the United States when received at a provider contracted with Cigna for the specific gene therapy product and related services.			
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	\$200 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	100%
Travel Maximum \$10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced cellular therapy is only covered in the United States when received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services.			
Advanced Cellular Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	\$200 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	100%
Advanced Cellular Therapy Travel Maximum: \$10,000 per episode of advanced cellular therapy	100%	In-Network Coverage Only	In-Network Coverage Only
(Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Maternity Care Services			
Initial Visit to Confirm Pregnancy Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Delivery - Facility Inpatient Hospital	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Birthing Center Contract Year Maximum: Unlimited	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Abortion Includes elective and non-elective procedures			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Infertility, Fertility and Conception Services	Not Covered	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants Physician Office Visit Inpatient Facility Travel Maximum: \$10,000 per transplant	\$40 per visit Copay, then 100% \$200 per admission Copay, then 100% 100% (only available when using Cigna LifeSOURCE Transplant Network® facilities)	In-Network Coverage Only In-Network Coverage Only In-Network Coverage Only	100% 100% In-Network Coverage Only
Durable Medical Equipment Contract Year Maximum: \$700	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Insulin Pumps Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Blood Glucose Meters Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Diabetic Supplies	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Nutritional Counseling Contract Year Maximum: 3 visits; the visit limit does not apply to treatment of diabetes Physician Office Visit Inpatient Facility Outpatient Facility	\$40 per visit Copay, then 100% \$200 per admission Copay, then 100% Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Nutritional Formulas Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Genetic Counseling Contract Year Maximum: 3 visits; for counseling, pre- and post-genetic testing Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an Injury to teeth. Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility Contract Year Maximum: \$1,000	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Alternative Therapies and Non-traditional Medical Services Herbalist, Massage Therapist, Naturopath Physician Office Visit Combined Contract Year Maximum: \$1,000	Not Covered	Not Covered	100%
Routine Foot Disorders Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.			
Mental Health Inpatient Includes Acute Inpatient and Residential Treatment Contract Year Maximum: 30 Days Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy; medication management Contract Year Maximum: 10 Visits Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Transcranial Magnetic Stimulation (TMS), etc. Contract Year Maximum: 10 Visits	\$200 per admission Copay, then 100% \$40 per visit Copay, then 100% Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Substance Use Disorder			
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Contract Year Maximum: 30 Days	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy, medication management Contract Year Maximum: 10 Visits	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient - All Other Services Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc. Contract Year Maximum: 10 Visits	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

Certification Requirements U.S. Out-of-Network For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient; except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements - U.S. Out of Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility, or a Physician's office. You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services and should be

requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Diagnostic Testing, and Outpatient Procedures

Including, but not limited to:

- advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Medical Pharmaceuticals.
- radiation therapy.

Prior Authorization/Pre-Authorized U.S.

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- radiation therapy.
- transplant services.



Coverage includes immediate access, without Prior Authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna and that are not otherwise excluded from coverage by the terms of this policy, and
- as determined by Cigna, Medically Necessary Covered Expenses may also include charges for generally accepted medical standards of care and practice.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.

Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and

laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.

- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for the treatment of diabetes as recommended in writing or prescribed by a Physician or Other Health Professional, including:
 - insulin pumps, blood glucose meters and diabetes self-management training;
 - alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips; and
 - insulin and pharmacological agents for controlling blood sugar.
- charges for chronic care management services.
- charges for treatment of autism spectrum disorder including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for Medically Necessary specialized treatment and support to secure access to dental care for children under age 21 with severe disabilities due to significant mental or physical condition, illness or disease.
- charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment,

diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider legally allowed to practice in the state or country and practicing within the health care provider's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health care provider is at a distant site.

- **Distant site** means a site at which a health care provider legally allowed to practice in the state or country is located while providing health care services by means of telemedicine or telehealth.
- **Originating site** means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth.
- **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Genetic Counseling

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for genetic testing. May be performed prior to and/or following the genetic test.

Nutritional Counseling

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas and foods, low protein modified formulas and modified food products, consumed or administered enterally (via tube or orally), which are prescribed as Medically Necessary by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism), and the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), when administered under the direction of a Physician.

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Alternative Therapies and Non-traditional Medical Services - Outside the U.S.

Charges for Alternative Therapies and Non-traditional medical services are limited to the amount shown in The Schedule. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, Naturopath or Massage Therapist for Massage Therapy, when these services are provided for a covered condition outside the U.S. in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is Medically Necessary, cost-effective, and provided in an appropriate setting.

Mental Health and Substance Use Disorder Services

The plan covers charges for mental health and substance use disorder services.

Mental Health Disorders are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

Substance Use Disorders involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.

- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)

Mental Health Acute Inpatient Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

Mental Health Residential Treatment Services are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center.

Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)

Outpatient Mental Health Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential

Treatment Center, for evaluation and treatment of a Mental Health Disorder.

Mental Health Partial Hospitalization Services are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Mental Health Intensive Outpatient Services are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)

Acute Inpatient Detoxification Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

Substance Use Disorder Inpatient Treatment Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Substance Use Disorder Residential Treatment Center.



Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)

Outpatient Substance Use Disorder Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

Substance Use Disorder Partial Hospitalization Services are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Substance Use Disorder Intensive Outpatient Services are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Substance Use Disorder Detoxification Services are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

Outpatient Therapy Services

Charges for the following therapy services when provided as part of a program of treatment: **Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Breast Reconstruction

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-

diseased breast to produce symmetrical appearance. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Transplant Services and Related Specialty Care

- charges approved by medical management for human organ and tissue transplant services including solid organ and bone marrow/stem cell procedures are covered subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered at the U.S. In-Network level when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities in the United States specifically contracted with Cigna for the requested transplant services and related specialty care services are payable at the U.S. In-Network level.
- Transplant services and related specialty care services received outside the United States are covered at the International level.
- Transplant services and related specialty care services received at any other facility, including non-Participating

Provider facilities and Participating Provider facilities in the United States not specifically contracted with Cigna for the requested transplant services and related specialty care services, are not covered.

- Cornea transplants received at a facility in the United States, that is specifically contracted with Cigna for this type of transplant are payable at the U.S. In-Network level.

Charges for gene therapy products and services directly related to their administration are not covered under the Transplant Services and Related Specialty Care benefit.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services In-Network coverage only

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not

related to you, but actively involved as your caregiver who is at least 18 years of age.

- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant and Related Specialty Care Services and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donors costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the U. S. In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider in the United States that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced cellular therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an inpatient setting, outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions.



Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product.

Utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

For a complete list of covered Medical Pharmaceuticals visit the website shown on your ID card or call the number on the back of your ID Card.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in

part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at United States In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other United States facilities are not covered.

Gene therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Health Care Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
 - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
 - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover **any** of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
 - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
 - an item or service that is not used in the direct clinical management of the individual;
 - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
 - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
 - mileage reimbursement for driving a personal vehicle;
 - lodging;
 - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.



Emergency Medical Evacuation and Repatriation Benefits

Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna, and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

If you or your Dependent suffer a medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You or your Dependent must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to the specific Medical Necessity of each case.

Repatriation Following a Medical Evacuation

Covered Expenses

Following any covered emergency medical evacuation, Cigna will pay for one of the following:

- if it is deemed Medically Necessary and appropriate by the Cigna Medical Director, you or your Dependent will be transferred to your permanent residence via a one-way economy airfare; or
- you or your Dependent will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Primary Repatriation to the Permanent Residence after a Serious Medical Event

Following a Serious Medical Event, if it is deemed Medically Necessary and appropriate by the Cigna Medical Director, Cigna may pay for you or your Dependent to be transferred to your permanent residence via a one-way economy airfare.

If the Cigna Medical Director determines that transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, determines a mode of transport other than economy class seating on a commercial

aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the Home Country will be covered. In addition, assistance will be provided by Cigna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you or your Dependent are expected to require hospitalization in excess of 3 days at the location to which you will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

Exclusions

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna, or its designee.
- non-emergency routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you.
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency medical evacuation or repatriation or a Primary Repatriation to the Permanent Residence after a Serious Medical Event.
- medical care or services scheduled for a member or a providers convenience which are not considered an emergency or a Serious Medical Event.
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- services provided for which no charge is normally made.
- expenses incurred while serving in the armed forces of another country.



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- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation.
 - services provided other than those indicated in this certificate.
 - housing/lodging or accommodations, meals or travel related expenses.
 - hotel and accommodations for covered Dependents post discharge or while awaiting fitness to fly approval.
 - Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
 - death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
 - claim payments that are illegal under applicable law.



Prescription Drug Benefits

Inside the United States

The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies in the U.S. as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

Supplemental Discount Programs

You and your Dependents will pay 100% of the cost of any Prescription Drug Products excluded from coverage under this plan. The amount you and your Dependent pay for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Copayments (Copay)

Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
	United States	United States
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Contract Year Deductible Individual Family	\$0 \$0	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the “Patient Assurance Program”. As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Contract Year Out-Of-Pocket Maximum Individual Family Maximum	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS		NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Network Pharmacy or home delivery Network Pharmacy.			
Immunizations and Contraceptives Note: Certain Immunizations and Contraceptives are payable at 100% when purchased from a Network US Pharmacy.			
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy	
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$20 Copay	25% after plan Deductible	
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$50 Copay	25% after plan Deductible	
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$75 Copay	25% after plan Deductible	
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy	
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.			
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$60 Copay	25% after plan Deductible	
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$150 Copay	25% after plan Deductible	
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$225 Copay	25% after plan Deductible	

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Network Pharmacies.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$60 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$150 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$225 Copay	In-network coverage only

Prescription Drug Benefits - U.S.

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations and Exclusions are provided below and are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on, which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, or Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your

Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier coverage status, utilization management, or other coverage limitations for a Prescription Drug Product.

Limitations

For most Prescription Drug Products you and your Dependent pay only the cost sharing detailed in The Schedule of Prescription Drug Benefits. However, in the event you or your Dependent insist on a more expensive Brand Drug where a Therapeutic Equivalent Generic Drug is available, you will be financially responsible for an Ancillary Charge, in addition to any required Brand Drug Copayment and/or Coinsurance. In this case, the Ancillary Charge will not apply to your Deductible, if any, or Out-of-Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.



Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. It is not necessary to obtain prior authorization in an emergency situation for a 72 hour supply of a non-controlled substance. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. If a prescriber indicates on the prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, a reauthorization for the same prescription medication will not be required more frequently than every 12 months. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies the patient for a step therapy exception. If the exception request is for a patient that is stable for the medical condition under consideration while on a Prescription Drug Product prescribed by the patient's health care provider, or prescribed under the patient's current or a previous insurance or health benefit plan, a step therapy determination will be considered granted until a step therapy determination is issued.

We will respond to the exception request with our decision within two (2) business days of receipt of the exception request. In the event we do not respond to an exception request within two (2) days, the exception request will be granted.



In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request. In the event we do not respond to an exception request within 24 hours for emergency circumstances, the exception request will be granted.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are beginning a therapy regimen on a Specialty Prescription Drug Product, we may limit your coverage for the initial Prescription Order or Refill to multiple, separate fills of less than the total days' supply set forth in The Schedule. If applicable, you will pay a pro-rated Coinsurance or Copayment amount for each such supply.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may receive reduced or no coverage for the Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New

Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Deductible

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule, if any. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest of the following amounts:

- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

The Schedule sets forth your costs for covered Prescription Drug Products after you have satisfied the Deductible amount.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a



Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy shall be determined by applying any applicable Deductible, non-Network Pharmacy Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a non-Network Pharmacy.

Any reimbursement due to you for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Copayment, Coinsurance, or other cost-sharing payment you owe.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for you or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, and fade cream products.
- Prescription Drug Products used for the treatment of infertility.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of



disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.

- prescription smoking cessation products.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan or wish to dispute the amount you were charged. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product. If you believe that the amount of any applicable Copayment, Coinsurance and/or Deductible you were charged was incorrect, to dispute the accuracy of the amount you were charged you must submit a claim for reimbursement according to the applicable claim filing procedures for postservice claims.

When you purchase a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit



Prescription Drug Benefits
International
Outside the United States
The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies outside the U.S. as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Contraceptives

Note: Contraceptive devices and oral contraceptives are payable as shown in The Schedule.

BENEFIT HIGHLIGHTS		INTERNATIONAL PHARMACY Outside the United States	
Lifetime Maximum		Refer to the Medical Benefits Schedule	
Contract Year Deductible			
Individual		\$0	
Family		\$0	
Contract Year Out-of-Pocket Maximum			
Individual		Refer to the Medical Benefits Schedule	
Family		Refer to the Medical Benefits Schedule	
Prescription Drug Products at Pharmacies Outside the United States		The amount you are required to pay	
		No charge	

Prescription Drug Benefits - International

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy outside the United States. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy outside the United States for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule.

Coverage also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an emergency medical condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a Pharmacy shall be determined by applying any applicable Deductible,

Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a Pharmacy. Any reimbursement due to you for a covered Prescription Drug Product dispensed by a Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Coinsurance, or other cost-sharing payment you owe.

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products purchased outside the United States:

- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products except where covered under the medical benefits.
- Prescription Drug Products furnished by the local, state or federal government.
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products used for the treatment of infertility.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.



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- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
 - medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or unless the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
 - certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
 - any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
 - prescription smoking cessation products.
 - medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
 - immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions.
 - medications that are not FDA-approved for any indication.
 - Prescription Drug Products classified as gene therapy.

Reimbursement/Filing a Claim

When you or your Dependents purchase covered Prescription Drug Products through a Pharmacy outside the United States, you must pay the Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.



Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- for charges made for Home Health Care Services.
- for charges made for Hospice Care Services.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment.
- Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action which occurs in the Member's Country of Citizenship.
- Injury or Sickness that results, directly or indirectly from: nuclear fission, fusion or radioactivity; nuclear, biological and chemical weapons and/or devices; or attacks on, or sabotage of, facilities and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents which occurs in the Member's Country of Citizenship.
- charges which you are not obligated to pay and/or for which you are not billed or for which you would not have been billed. This exclusion includes, but is not limited to:
 - any instance where Cigna determines that a provider or pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
 - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
- deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
- reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.
- not considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved

labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature and is considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the "Reconstructive Surgery" benefits: macromastia surgery; gynecomastia surgery; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) disorders.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an Injury to teeth are covered provided a continuous course of dental treatment is started within six months of the Injury.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government

licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.

- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth

announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as covered under this plan as shown in the Covered Expenses section.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books, except as shown in the Covered Expenses section for treatment of autism.
- corrective lenses, eyeglass lenses and frames, contact lenses and associated services (exams and fitting), except the initial prescribed set or pair after treatment of keratoconus or following cataract surgery.
- routine refractions, and eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- acupuncture.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs and weight loss programs.
- charges for smoking cessation treatment.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in

anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.
- health and beauty aids, cosmetics and dietary supplements.
- enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except as specifically provided in the “Enteral Nutrition” benefit.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker’s compensation or similar laws.
- the cost of treatment or services that are provided without charge by a Student Health Center or rendered by a person employed by the Participating Sponsor/Group, including, but not limited to team doctors and trainers, or other services performed at no cost.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- to the extent that payment is unlawful or prohibited by applicable sanctions rules.
- for elective or pre-scheduled treatment in sanctioned countries.
- for any person whom Cigna considers to be “ordinarily resident” in a sanctioned country. A person is considered “ordinarily resident” if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.
- for charges made for any service that is not covered by the terms of this policy or for coverage declined, or otherwise not elected by you, at enrollment.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- any charges related to care provided through a public program.
- to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.



- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs, or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's Family.
- for claim payments that are illegal under applicable law.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under any government health insurance plan.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the

Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:



- The Plan that covers you as an enrollee or a member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or member;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the parent not having custody of the child, and
 - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active member or retiree (or as that member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Expenses for Which a Third Party May be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), occupational disease law, any employers' liability insurance or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.



Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of

recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits

Medical

Assignment and Payment of Benefits

You may authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize



the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment within twenty-four (24) months after the payment is made. The 24 month limit will not apply if there is reasonable belief of fraud, abuse or other intentional misconduct, or if required by a state or federal government plan. In addition, your acceptance of benefits under this plan and/or assignment of Medical, Dental and Vision benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Termination of Insurance – Members

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by the Group. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date the Group stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which the Group stops paying premium for you or otherwise cancels the insurance.

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent insurance.
- the date Dependent insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.



Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums, and you or your Dependent is Confined in a Hospital on that date), Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the Hospital Confinement;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

You are entitled to receive free upon request access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be notified of the final decision in a timely manner, as described in your plan materials.

If you are still not satisfied with our final decision to your complaint or appeal, you can refer your complaint or appeal to the Channel Islands Financial Ombudsman Service at the address below:

The Channel Islands Financial Ombudsman (CIFO)
PO Box 114
Jersey, Channel Islands
JE4 9QG
Telephone: +44 (0)1534 748610
Fax: +44 (0)1534 747629
Email: enquiries@ci-fo.org
Website www.ci-fo.org

When You Have an Appeal or Complaint

If you have questions, disagree with the determination of a claim, or have a complaint, you may contact Cigna at the address indicated below. A written request for a claim review must be sent in writing within 365 days of receipt of a denial notice to:

Cigna

Attn: Appeals & Complaints

P.O. Box 15800

Wilmington, DE 19850 USA

For a claim review, you should state the reason(s) why you feel your claim should have been approved. Send a copy of the denial along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. For questions, please contact the **Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).**

It is important to include your Name, Group Number, Member/Patient ID Number, Name of the patient and relationship, and "Attention: Appeals" on all supporting documents.



Definitions

Active Service/Enrollment

You will be considered in Active Service/Enrollment:

- on any of your Group's scheduled work/enrolled days if you are performing the regular duties of your work on a full-time basis or studying as determined by your group on that day either at your Group's place of business or academic institution or at some location to which you are required to travel for your Group.
- on a day which is not one of your Group's scheduled work/academic days if you were in Active Service on the preceding scheduled work day.

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

Chiroprapist

See Podiatrist



Cigna LifeSOURCE Transplant Network®

The Cigna LifeSOURCE Transplant Network® consists of designated In-Network facilities that have met quality and cost criteria and have contracted with Cigna LifeSOURCE to provide transplant services as a Participating Provider in the Cigna LifeSOURCE Transplant Network®. In order to be considered a facility in the Cigna LifeSOURCE Transplant Network®, the facility must be a designated program for the specific type of transplant requested.

Country of Citizenship

Country of Citizenship is the nation of the Member or Dependents' birth or the country in which they have subsequently been naturalized or granted legal citizenship or recognition.

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is:
 - less than 26 years old.

- 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability, or intellectual disabilities or a physical handicap which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a Member will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Member coverage. A child under age 26 may be covered as either a Member or as a Dependent child. You cannot be covered as a Member while also covered as a Dependent of a Member.

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

Emergency Services

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the



staff and facilities available at the Hospital, to stabilize the patient.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

Group

The term Group means an eligible organization or plan sponsor.

Herbalist

The term Herbalist means a non-medical practitioner who specializes in treating disorders with natural remedies derived exclusively from plant materials.

Home Country

Home Country is the nation in which the Member or Dependents have their permanent place of residence prior to an expatriate assignment and/or the indefinite intention to reside post assignment.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;



- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, or is appropriately accredited where located as determined by Cigna; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician; and
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Drug Product by calling member services at the telephone number on your ID card.

Massage Therapist

The term Massage Therapist means a person who is licensed to apply manipulation, methodical pressure, friction and kneading to the body.

Maximum Reimbursable Charge - Medical Services in the United States

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay an Out-of-Network health care provider for a Covered Expense. Your applicable Out-of-Network Copayment, Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, Out-of-Network providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from an Out-of-Network provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If an Out-of-Network provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the Out-of-Network allowable amount for a Covered Expense. An Out-of-Network provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party vendors that establishes the rate the Out-of-Network provider is willing to accept as payment for the Out-of-Network Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If an Out-of-Network provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the provider's normal charge for a similar service or supply; or
- a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge is 150%.

The Maximum Reimbursable Charge is subject to all other benefit limitations and exclusions and Cigna's applicable Coverage Policies, Reimbursement Policies, and other coding and payment methodologies. Additional information about



how Cigna determines the Maximum Reimbursable Charge is available upon request.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Copayment, Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

Maximum Reimbursable Charge – Medical and Pharmacy Services Outside the United States

Maximum Reimbursable Charge for services outside the United States is determined based on:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- Reasonable and Customary expenses. Medical expenses will be considered Reasonable and Customary if they (i) correspond to the normal charge for the service by providers in the locality where the service is rendered or performed; and (ii) the services are provided according to established clinical and medical practice.

Telehealth expenses should not exceed the cost of an equivalent face-to-face consultation.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable payment methodologies determined by Cigna.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

Cigna is not obligated to pay excessive charges.

Medicaid – U.S.

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or Other Health Professional within the

scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on, the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia, peer-reviewed, evidence-based scientific literature or guidelines and generally accepted medical standards of care and practice.

Medicare - U.S.

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.



Member

The term means faculty, chaperone, fellows, volunteer, and student of a school who is in study abroad program, who is currently enrolled and for whom premiums have been paid of the Group outside their country of residence.

Naturopath

The term Naturopath means a non-medical practitioner who specializes in treating conditions by making reforms to the diet and lifestyle of the patient.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under the Group's plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.", "L.P.N." or "L.V.N.".

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is appropriately licensed and/or certified by the appropriate authorizing agency to deliver Medically Necessary services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.



Participating Provider - Medical

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies in the U.S., the charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the charges for which are Covered Expenses. Covered services and/or supplies received from Participating Providers are considered In-Network.

Participating School

The term Participating School means a Higher Education participating in the Trust to which this policy is issued.

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Podiatrist

The term Podiatrist means a licensed practitioner responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot. A Podiatrist performs surgical procedures, prescribes corrective devices, drugs and physical therapy.

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

Prescription Drug Charge - International and U.S. Non-Network Pharmacies

The Prescription Drug Charge is the amount for a specific covered Prescription Drug Product dispensed at a Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax.

Prescription Drug Charge - U.S. Network Pharmacies

The Prescription Drug Charge is the amount established by Cigna for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax. This amount is established in connection with the overall Prescription Drug Product pricing implemented in relation to the premium negotiated between Cigna and the plan sponsor.

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by the Group as part of the plan. The list is subject to periodic review and change and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug



Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- certain durable products and supplies that support drug therapy;
- certain diagnostic testing and screening services that support drug therapy;
- certain medication consultation and other medication administration services that support drug therapy; and
- certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

The following diabetic supplies are also included under this definition: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been selected by you and is contracted as a Primary Care Physician, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any

other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness – Medical

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or



restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Student Health Center

The term means primary care clinics based on primary or secondary school campuses in the United States.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of twelve months or less to live, as diagnosed by a Physician.

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Usual and Customary (U&C) Charge - Prescription Drugs

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.



CIGNA GLOBAL HEALTH BENEFITS EUROPE DATA PROTECTION NOTICE

As a provider of quality healthcare around the world, our customers and clients expect us to carefully handle and protect the Personal Information (as defined below) they share with us.

You are receiving this Data Protection Notice either because your group has signed an agreement with us, as an insurance company, to provide you, directly or through our partners, with international health insurance cover and other additional covers and services as it may apply (referred to in this Data Protection Notice as the “Services”), or you otherwise benefit from our Services (for example, as a dependent).

In order to provide our Services to you, we will collect and use your Personal Information. This Data Protection Notice explains how and why we do this, and outlines your rights in relation to your Personal Information.

Depending on the specific terms and conditions of our insurance agreement with the group, your Personal Information may be collected by any of the following entities (including but not limited to):

- Cigna Life Insurance Company of Europe S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Brussels, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial Services and Markets Authority in the field of consumer protection.
- Cigna Life Insurance Company of Europe S.A.-N.V., UK Branch, a foreign branch of Cigna Life Insurance Company of Europe, S.A. N.V., with corporate address at 5 Aldermanbury Square, 13th Floor, London, England, EC2V 7HR and authorized by the National Bank of Belgium and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority in the UK.
- Cigna Europe Insurance Company S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Belgium, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial

Services and Markets Authority in the field of consumer protection.

- Cigna Europe Insurance Company S.A.-N.V., Brussels, Zurich Branch, a foreign branch of Cigna Europe Insurance Company S.A.-N.V., with corporate address at Europaallee 41, 8004 Zurich, Switzerland, existing under the laws of Switzerland, and registered in the commercial register of Canton Zurich.
- Cigna Global Insurance Company Limited with corporate address in Guernsey at P.O. Box 155, Mill Court, La Charroterie, St Peter Port, Guernsey GY1 4ET 67, and subject to the prudential supervision of the Guernsey Financial Services Commission for the conduct of insurance business.

The company collecting your Personal Information depends on the insurance entity which provides your insurance cover and can be found in your member booklet or certificate of insurance. This company will be the data controller of the Personal Information collected to provide the Services to you.

In addition to this Data Protection Notice, some of our products and services may have their own notices (for example, the [Cigna Online and Mobile Privacy Notice](#), which describes in more detail how your Personal Information is used in a particular context).

PERSONAL INFORMATION

“Personal Information” is the information that identifies and relates to you, or to other individuals which also benefit from our Services, such as your dependents. Your Personal Information may be provided to us by yourself or by a third party entitled to provide us with such information (e.g. your health care providers, your group, etc.).

Due to the nature of the Services you are entitled to, your Personal Information may contain sensitive data including, but not necessarily limited to, your medical condition and health status.

THE TYPES OF PERSONAL INFORMATION WE COLLECT

The Personal Information we collect includes:

- > General information such as your name, address, contact details, date of birth, gender, relationship to the policyholder (where you are not the policyholder);
- > Identification information such as your national identification number, passport number or driving license number;
- > Information linked to the provision of the Services (for example, to review and pay your claims; to issue guarantee of payment/s when applicable);
- > Information about your job including job title or any other that may be strictly required to provide the Services to you, provided that there is a connection between the access to the Services and your job or job title;
- > Information relating to previous policies or claims;
- > Financial information such as your bank or payment details;
- > Telephone recordings and other logs of your correspondence with us; and
- > Sensitive data including details of your current and past physical and/or mental health.

We collect the Personal Information outlined above from a number of different sources, including from:

- > You directly, or from someone else on your behalf (such as a family member that you have formally authorized to do so);
- > Healthcare providers and other medical providers, and other third parties that are required to provide the Services to you (for example loss adjusters, claims handlers, experts (including medical experts));
- > Other third parties involved in the provision of the Services or linked to that provision such as a broker or another insurer, claimants, defendants;
- > Your group (as it may be applicable);

- > Medical reports and counsel opinions;
- > Emergency assistance;
- > Other companies within the Cigna corporate group as may be appropriate to provide the Services to you; and
- > Insurance industry fraud prevention and detection databases and sanctions screening tools.

As we are required to collect your Personal Information as a consequence of a contractual agreement with the group failure to provide this information may prevent or delay the fulfilment of these obligations. For example, if you do not provide certain Personal Information, we will not be able to provide you with the Services.

PURPOSE AND USE OF PERSONAL INFORMATION

Your Personal Information is collected in order to provide the Services, administer your plan and, in general, conduct insurance business in line with the Services you are entitled to. We use your Personal Information to:

- > Provide insurance and assistance services including, for example, claim assessment, processing and settlement; and, where applicable, handle claim disputes;
- > Communicate with you and others, including the group, as part of our Services;
- > Send you important information regarding changes to our policies, other terms and conditions and other administrative information;
- > Make non-automated decisions about whether to provide the Services to you;
- > Provide improved quality, training and security (e.g. with respect to recorded or monitored phone calls to our contact numbers);



- > Continuously improve and test the quality of our Services (for example, conducting satisfaction surveys, research and analysis related to the Services);
- > Protect our business against fraud. This includes searching claims or fraud registers when dealing with insurance requests or claims in order to detect, prevent and investigate fraud;
- > Manage our infrastructure and business operations, and comply with internal policies and procedures, including those relating to auditing; finance and accounting; billing and collections; IT systems; business continuity; and records, document and print management;
- > Resolve complaints and handle requests;
- > Comply with applicable laws and regulatory obligations, including those relating to anti-money laundering and anti-terrorism; and respond to requests from public and governmental authorities and litigation; and
- > Establish and defend legal rights; protect our operations or those of any of our group companies or insurance business partners; safeguard our rights, privacy, safety or property, and/or that of our group companies, you or others; and pursue available remedies or limit our damages.

As outlined above, we may use your Personal Information for a number of different purposes that are always connected with the Services we provide. Consequently, we will rely on the following legal grounds to use your Personal Information:

- > The use of your Personal Information is necessary for the performance of a contract to which you are a party;
- > We have a legal or regulatory obligation to use your Personal Information. For example, we will rely on this ground to comply with anti-money laundering and anti-terrorism obligations; and
- > We have a legitimate interest in using your Personal Information. We may rely on this legal ground for the purpose of providing improved quality, training and managing our infrastructure and operations. When collecting and processing your Personal Information under this ground we put in place robust safeguards to ensure that your privacy is protected and that our legitimate interests are not overridden by your interests or fundamental rights and freedoms.

Due to the nature of the Services you are entitled to, we may process sensitive data connected with the provision of such Services. In general, your consent is not required since we are permitted by applicable law to process such information as a healthcare insurance company. However we may collect your consent in specific situations where either the nature of the data to be disclosed and/or the requirements on the jurisdiction where you are on assignment or other applicable laws and regulations may require that consent.

DISCLOSURE OF YOUR PERSONAL INFORMATION

If necessary for providing you with the Services you are entitled to, or for any of the purposes described in this Data Protection Notice, we may disclose your Personal Information with other parties. Disclosing your Personal Information means that we will provide your Personal Information to and/or that your Personal Information will be accessed by:

- > Cigna group companies. Access to Personal Information within Cigna is restricted to those individuals and entities who have a requirement to access the information for the purposes described in this Data Protection Notice;
- > Other insurance and distribution parties, such as other insurers; reinsurers; brokers and other intermediaries and agents and appointed representatives;
- > Healthcare providers and travel and medical assistance providers;
- > External third-party service providers, such as IT systems, support and hosting service providers; document and records management providers; translators; and similar third-party vendors and outsourced service providers that assist us in carrying out business activities;
- > External professional advisors and partners such as medical professionals, accountants, actuaries, auditors, experts, consultants, lawyers; banks and financial institutions that service our accounts; claim investigators, adjusters and others;
- > Investigative firms we brief to look into claims on our behalf in relation to suspected fraud;
- > Our regulators and other governmental or public authorities where necessary to comply with a legal or regulatory obligation;

> The police and other third parties or law enforcement agencies, court, regulator, government authority or other similar third parties where necessary for the prevention or detection of crime or to comply with a legal or regulatory obligation; or otherwise to protect our rights or the rights of a third party;

> Debt collection & Subrogation agencies;

> Selected third parties in connection with any sale, transfer or disposal of our business;

> Other third parties, such as emergency providers (fire, police and medical emergency services) and travel carriers;

> Your group or a company acting on your group's behalf to monitor, audit or otherwise administer the Services and fulfil contractual obligations in relation to the Services. Consequently, the Personal Information that may be shared will be the minimum necessary to perform the Services you are entitled to. Under no circumstances will Cigna provide any sensitive information (i.e. medical information related to you) to the group without asking for previous express consent from you;

> In addition to the above, we may need to share limited Personal Information with the group in case of an emergency medical evacuation or repatriation ("Emergency") to ensure that your health and safety and the best outcome for you, in case of an Emergency when outside your home country, is achieved. Please be aware that during an Emergency we will try to prevent the immediate and significant effects of illness, injury or conditions which if left untreated would result in a significant deterioration of health and represent a threat to your life. During the complexity of those situations the interaction with your group may be required to provide additional assistance to try to ensure the best possible outcome during an evacuation and/or assess whether to provide other assistance to you out-with the Cigna plan. The Personal Information that may be shared will be the minimum necessary to conduct the evacuation or repatriation in line with the Services you are entitled to. The information that will be shared may be: date of evacuation or repatriation; location where the patient will be evacuated or repatriated from or to; medical conditions which has resulted in the need for the evacuation or repatriation and the medical necessities of the patient during the Emergency. Once you are safely medically repatriated or evacuated that sharing of information will cease immediately; and

> Registers of claims which are shared with other insurers in order to check information to detect and prevent fraudulent claims. The Personal Information put on these registers may include details of injuries.

For any of the categories of the recipients listed above, it should be noted that some of them may be located in the European Economic Area, while others can process and access your Personal Information from outside the European Economic Area, as described in the following section of the Data Protection Notice.

INTERNATIONAL TRANSFER OF PERSONAL INFORMATION OUTSIDE THE EUROPEAN ECONOMIC AREA

Due to the global nature of the Services you are entitled to and the need to provide the group with compliance solutions to meet its needs and ensure that you have access to the Services in the location of your assignment, your Personal Information can be shared with and/or accessed by parties located in other countries outside the European Economic Area that have a different data protection regime than the one found in the country where the group, signing the contract with us, is located. The countries to which we may transfer your Personal Information may not be regarded by the European Commission as ensuring an adequate level of protection for Personal Information (for instance, the United States).

In any case, where we transfer your Personal Information to any of these countries, we will conduct the transfer in accordance with applicable data protection law. This may include ensuring that appropriate safeguards, such as contractual obligations, are put in place with respect to the protection of your Personal Information and your fundamental rights and freedoms, and your rights in relation to your Personal Information. If you would like further information regarding the steps we take to safeguard your Personal Information, or to obtain a copy of the safeguards we put in place to protect it when it is transferred, please contact us using the details in the "Contact Us" section below.

Depending on the country of your assignment or location and the compliance requirements that may apply there you may receive additional privacy notices from us or from our partners.

RETAINING YOUR PERSONAL INFORMATION

We ensure that proper procedures are in place to manage your Personal Information and to remove and/or archive it when necessary.

In general terms, we only retain your Personal Information for as long as is necessary to:

- > Provide you with the Services;
- > Fulfil the purposes outlined in this Data Protection Notice; and
- > Comply with our legal obligations and/or protect our rights.

When your group instructs us to terminate your access to the Services, we will protect your Personal information and will delete it once our retention period to comply with our legal or regulatory obligations and/or protects our rights has lapsed. Our default retention period is 10 years. However, depending on the jurisdiction that governs our contract and the type of information involved, our general retention period may vary between 7 to 10 years.

If you would like further information regarding the periods for which your Personal Information will be stored, please contact us using the details in the “Contact Us” section below.

MARKETING

We may use your Personal Information to provide you with information about our products and services where you have provided your consent for us to do so. In certain circumstances, we may also use your Personal Information to contact you for marketing purposes where we have a legitimate interest to do so, in order to provide you with information about our other products or services which we consider may be of interest to you. If you wish to unsubscribe from emails sent by us, you may do so at any time by clicking on the "unsubscribe" link that appears in all emails. Otherwise you can always contact us using the details set out in the “CONTACT US” section below to update your contact preferences. Please note, however, that we will continue to send you service related (non-marketing) communications.

YOUR RIGHTS

Under data protection law you have certain rights in relation to the Personal Information that we hold about you. You may exercise, as may be applicable, these rights at any time by contacting us using the details set out in the “Contact Us” section below.

Your rights include:

The right to access your Personal Information

You are entitled to a copy of the Personal Information we hold about you and certain details about how we use it. There will not usually be a charge for dealing with these requests.

Your information will usually be provided to you in writing, unless otherwise requested, or where you have made the request by electronic means, in which case the information will be provided to you by electronic means where possible.

The right to rectification

We take reasonable steps to ensure that the Personal Information we hold about you is accurate and complete. However, if you do not believe this is the case, you can ask us to update or amend it.

The right to erasure

In certain circumstances, you have the right to ask us to erase your Personal Information. Please note that in some circumstances exercise of this right will mean we are unable to continue providing you with the Services as outlined above.

The right to object to, and/or to request restriction of processing

In certain circumstances, you are entitled to object to our processing of your Personal Information, or ask us to stop using your Personal Information. Please note that in some circumstances exercise of these rights will mean we are unable to continue providing you with the Services.

The right to data portability

In certain circumstances, you have the right to ask that we provide your Personal Information to you in a commonly used electronic format, and to transfer any Personal Information



that you have provided to us to another third party of your choice.

The right to object to marketing

You can request that we stop sending you marketing messages at any time by clicking on the "unsubscribe" button in any emails that we send to you or by contacting us using the details set out in the "CONTACT US" section of this Data Protection Notice. Please note that even if you exercise this right because you do not want to receive marketing messages, we may still send you service related communications where necessary.

The right not to be subject to automated decision-making (including profiling)

You have a right in some circumstances to not be subject to a decision based solely on automated means, but we do not base our decisions only on automated means.

The right to withdraw consent

As explained previously, we collect and process your Personal Information (including sensitive data) to provide the Services under different grounds, so that is why we do not ask for your consent.

The right to lodge a complaint with a data protection authority

You have a right to complain to your local data protection authority if you believe that any use of your Personal Information by us is in breach of applicable data protection laws and regulations.

Making a complaint will not affect any other legal rights or remedies that you have.

SECURITY

We will take appropriate technical, physical, legal and organizational measures, which are consistent with applicable data protection laws to protect your Personal Information.

CHANGES TO THIS DATA PROTECTION NOTICE

We may update this Data Protection Notice from time to time to ensure that it remains accurate. Please check back each time

that you provide additional Personal Information to us. Where changes to the Notice will have a fundamental impact on the nature of our processing of your Personal Information, or otherwise have a substantial impact on you, we will give you sufficient advance notice so that you have the opportunity to exercise your rights in relation to your Personal Information.

This Data Protection Notice was last updated August 2022.

CONTACT US

Data Protection Officer
Plantin en Moretuslei 309 2140
Antwerp, Belgium
Belgium Email: CGHB-EU-Privacy@cigna.com

CIGNA GLOBAL INSURANCE COMPANY LIMITED

*Address: P.O. Box 155
Mill Court
La Charroterie
St Peter Port Guernsey GY1 4ET*

CIGNA GLOBAL INSURANCE COMPANY LIMITED

POLICYHOLDER: Cigna Global Wellbeing Solutions Limited

PARTICIPATING SPONSOR: Louisiana Tech University

ADDRESS: London, United Kingdom

PARTICIPATING SPONSOR/NUMBER: 10676A

<u>Group Insurance Policy and Policy Number</u>	<u>Effective Date</u>	<u>Anniversary Date</u>
MEDICAL BENEFITS (OPEN ACCESS PLUS)	09/01/2025	09/01
EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS	09/01/2025	09/01

This Policy is issued in Guernsey and shall be governed by its laws.

These Policies contain the terms under which the Insurance Company agrees to insure certain Members and pay benefits.

The Insurance Company and the Participating Sponsor have agreed to all of the terms of these policies.

These materials are being made available electronically for your convenience. Should you have any questions regarding content, please feel free to contact Cigna. A printed document will be provided upon request.



Jennifer Laydon
Financial Analysis Director

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CIGNA GLOBAL INSURANCE COMPANY LIMITED

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the Policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the Certificate to "you" or "yours" refers to the Member.

A Member in any of the classes shown below may be insured but only for the Policy(ies) listed for his Member Class. The Effective Date shown below is the date on which a Policy becomes effective for a Member Class.

A Member will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

GROUP POLICY(IES)		MEMBER CLASS	
<u>Certificate Number</u>	<u>Policy(ies)</u>	<u>Eligible Members</u>	<u>Effective Date</u>
CN001	Medical Benefits (OPEN ACCESS PLUS) Emergency Medical Evacuation And Repatriation Benefits	Students: each member identified as a student by the Participating Group	09/01/2025

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Participating Sponsor and the Insurance Company agree on some other method of premium payment. The Participating Sponsor and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the Policy becomes effective. If the Participating Sponsor and the Insurance Company agree that premiums will be paid on a quarterly, semester, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, by semester, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the Policy will be cancelled except as set forth in the Grace Period.

STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semester, semiannual or annual basis, the Statement Date will be the same number as the Premium Due Date.

PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, by semester, semiannually or annually, a Premium Statement will be prepared as of the Statement Date for the applicable time period. This Statement will reflect any pro rata premium charges and credits due to changes in the number of insured members and changes in insurance amounts that took place in the preceding period.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Statement Date that is the same as or next follows the date that:

- A member becomes insured.
- The amount of insurance on a member changes, but not due to a revision of The Schedule.
- A member ceases to be insured.

PREMIUM RATE FOR MEDICAL EXPENSE INSURANCE. The monthly premium rate for Medical Expense Insurance is determined by written agreement between the Participating Sponsor and Cigna Global Insurance Company Limited.

MEDICAL EXPENSE INSURANCE PREMIUM. The monthly premium for Medical Expense Insurance will be calculated as follows:

- Multiply the number of subscribing Members insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
- Add the results.

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. If daily rates are selected, the Insurance Company calculates by using the monthly rate for each class multiplied by 12, then divided by 365 to produce the daily rate. The daily rate is used to calculate the semester premium, depending on the number of days in each semester. All results are taken to the nearer cent. If the Participating Sponsor and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 60 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by 15% or more.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date:

- if the Participating Sponsor fails to provide sufficient information, as required by the Insurance Company to confirm adequacy of premiums currently being paid; or
- any reinsurance obtained by the Insurance Company in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by 15% or more, or the Insurance Company's retention increases by 15% or more.

As of any Anniversary Date after the Policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this Policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the Participating Sponsor or its Members.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in governing law or by a revision in the insurance under the Policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

PREMIUM EXCLUSIVE OF INDIRECT TAXES. All fees charged by the Insurance Company are exclusive of any applicable indirect taxes which are the liability of the Participating Sponsor including but not limited to value-added tax, goods and services tax, sales or use tax, or other similar taxes. If Insurance Company determines it is required to collect and remit any such taxes on the Participating Sponsor's behalf, Insurance Company will include such charges in the manner and at the rate prescribed by law.

Experience for Pooled Coverage under this Policy may be combined with the experience for coverage which is deemed pooled under other group insurance policies providing similar insurance issued by the Insurance Company.

POOLED COVERAGE. Pooled Coverage means any Medical Benefits paid for a member in a policy year while this coverage is in force after a certain level of benefits have already been paid in that year for him.

CHANGE IN WAR RISK COVERAGE PREMIUM

The premium, the benefits, and the territorial area for the War Risk coverage provided thereby (or any one or more of them) may be revised by agreement between the Insurance Company and the Participating Sponsor at any time, to reflect a change in the war risk exposure.

CANCELLATION OF POLICY

The Participating Sponsor may cancel the Policy as of any Premium Due Date by giving written notice to the Insurance Company before the date.

In the event the Participating Sponsor cancels the Policy on a Premium Due Date which is other than the Policy Anniversary Date, the Insurance Company will return the unearned portion of premium paid.

The Insurance Company may cancel the Policy due to the following reasons only:

- with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable governing law;
- as of any Premium Due Date, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;
- as to a Participating Sponsor to which this Policy is issued, immediately, if the Participating Sponsor has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;
- as of any Premium Due Date, if the number of insured Members fails to meet the minimum required per Participating Sponsor participation rules; or for failure to comply with any other material plan provision relating to Participating Sponsor contributions or Participating Sponsor participation rules;
- if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable governing law;
- in accordance with any applicable governing law, if it is determined that the size of the Participating Sponsor has changed, making such Participating Sponsor eligible for a guaranteed issued small group product;
- in accordance with any applicable governing law, if prior notice is given to the Participating Sponsor;
- as to a Participating Sponsor member of an association to which this Policy is issued, when the Participating Sponsor's membership in the association ceases, in accordance with applicable governing law.

In the event of termination by the Insurance Company, the Insurance Company shall compute the earned premium and promptly return the unearned portion of premium paid. Premium adjustment may be made either at the time termination is effective or as soon as practical after termination becomes effective, but payment or tender of unearned premium is not a condition of termination.

In the event of termination of war risk coverage the earned premium will be computed.

Notwithstanding anything to the contrary in the Policy, either the Participating Sponsor or the Insurance Company may terminate War Risk coverage upon written notice to the other. Termination by the Participating Sponsor shall become effective upon receipt of such written notice mailed to or delivered to the Insurance Company's Home Office, or on a later date if specified in such notice. Termination by the Company shall become effective upon the date specified by us in such written notice mailed or delivered to the Participating Sponsor at the last address shown in the Insurance Company's records. In no event shall it become effective in less than ten (10) days after such notice is mailed or delivered.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this Policy may be modified to reflect product revisions which have been uniformly made to this product.

PARTICIPATING PLAN SPONSOR GRACE PERIOD. If, before a Premium Due Date, the Participating Sponsor has not given written notice to the Insurance Company that the Policy is to be canceled, a Grace Period of 90 days will be granted for

the payment of each premium attributable to the membership after the initial premium. The Policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the Policy will automatically be canceled at the end of the Grace Period; except that, if the Participating Sponsor has given written notice in advance of an earlier date of cancellation, the Policy will be canceled as of the earlier date. The Participating Sponsor will be liable to the Insurance Company for any unpaid premium for the time the Policy was in force.

MEMBER GRACE PERIOD. Members will not have a grace period for premium payment under this policy. Eligibility terms require adherence to the method of premium payment agreed to by the Participating Plan Sponsor and the Insurance Company. Payment must be made by the member in accordance to the policy in order to be enrolled in the benefit coverage.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The Policy is executed at the Home Office of the Insurance Company. The address of the Insurance Company is:

St Martin's House
Le Bordage
St Peter Port, Guernsey GY 14AU.

COMPLIANCE. The Insurance Company's products and services may not be available in all jurisdictions and are expressly excluded from this Policy where prohibited by applicable law.

SANCTIONS: It is the Insurance Company's Policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. The Insurance Company will not offer coverage or pay benefits to or on behalf of any member if doing so would violate these sanctions rules. In the event the Insurance Company learns that a sanctioned individual or entity is enrolled under this Policy, or that a Participating Sponsor becomes sanctioned, the Insurance Company will take all appropriate action, which could include blocking, reporting, and terminating coverage. The Insurance Company is under no obligation to notify the member or Participating Sponsor in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions rules.

In addition, restrictions will apply to claims incurred in sanctioned countries in the absence of an approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, the Insurance Company will not cover: (1) elective or pre-scheduled treatment in sanctioned countries; or (2) members considered "ordinarily resident" in a sanctioned country. A member is considered "ordinarily resident" if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.

CONSIDERATION. The Policy is issued to the Participating Sponsor in consideration of payment of premiums.

INSURANCE DATA. The Participating Sponsor will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Participating Sponsor to give this data will not void or continue a Member's insurance. The Insurance Company has the right to examine the Participating Sponsor's records relative to these benefits at any reasonable time while the Policy is in effect. It also has this right until all rights and obligations under the Policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

COMPLAINTS. Any complaint should in the first instance be sent to the Insurance Company at:

Cigna
Attn: Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

If the complaint is not resolved to your satisfaction, you may raise the complaint to the Channel Islands Financial Ombudsman Service at:

The Channel Islands Financial Ombudsman (CIFO)

P.O. Box 114

Jersey, Channel Islands

JE4 9QG

Telephone: +44 (0)1534 748610

Fax: +44 (0)1534 747629

Email: enquiries@ci-fo.org

Website www.ci-fo.org

ADDITIONAL PROGRAMS. The Insurance Company may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Members for the purpose of promoting their general health and well-being. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Participating Sponsor. Contact the Insurance Company for details of these programs.

We do not provide tax advice. Consult your financial or tax adviser for information about appropriate tax treatment of benefit payments and reimbursements.

INCONTESTABILITY. The validity of the Policy shall not be contested after it has been in force for two years from the Policy Effective Date except for non-payment of premium. No statement made by any member covered under the Policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such member's lifetime nor unless it is contained in a written instrument signed by him or her; provided however, that no such provision shall preclude the assertion at any time of defenses based upon the member's ineligibility for coverage under the Policy or upon other provisions in the Policy.

OTHER PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the Policy, the application of the Participating Sponsor, a copy of which is attached to the Policy and all subsequent versions of the Policy, and the applications, if any, of the Members.

POLICY CHANGES. Changes may be made in the Policy only by amendment signed by the Participating Sponsor and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the Policy.

STATEMENTS NOT WARRANTIES. All statements made by the Participating Sponsor or by an insured Member will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Participating Sponsor or by the Member to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Participating Sponsor or the Member and a copy is sent to the Participating Sponsor, the Member or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Participating Sponsor for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within one year (365 days) after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within one year (365 days) after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any member for whom claim is pending as often as it may reasonably require.

RIGHT TO KNOW: The Participating Sponsor has the right to obtain information about how the plan operates the care delivery system and an explanation of the benefits to which participants are entitled under the terms of the plan. Additional information regarding the plan may be obtained by contacting the Participating Sponsor's sales office.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the Policy until at least 90 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the Policy.

TIME LIMITATIONS. If any time limit set forth in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the locale in which the Member lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

CERTIFICATES. The Insurance Company will issue to the Participating Sponsor for delivery to each insured Member an individual Certificate. The Participating Sponsor will be responsible for distributing the Certificates to its Members. The Certificate will show the benefits provided under the Policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the Certificate will change or void the terms of the Policy.

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Member or Dependent must be given to the Insurance Company within (90) days of the loss of eligibility. Upon receipt of such notice, the Insurance Company will assess whether the Member or Dependent incurred a claim on or after the requested termination date, and if so, the Insurance Company will process the termination of eligibility to be effective after the most recent date of service unless otherwise agreed by the Insurance Company in writing. If written notice of the termination of eligibility of any Member or Dependent is not received by the Insurance Company within (90) days of the date of loss of eligibility for an

Member or Dependent, then the Participating Sponsor shall be responsible for all claims for that Member or Dependent incurred after the requested termination date.

RIGHT TO AUDIT. The Insurance Company reserves the right to audit the Participating Sponsor's billing records and premium accounting practices. If we discover:

- an underpayment of premium by the Participating Sponsor—, the Participating Sponsor will be obligated to pay the underpayment amount, in a timely manner; or
- an overpayment of premium, we will return any overpayment amount in a timely manner.

CLERICAL ERROR. Clerical error or delays in making entries on the records by the Insurance Company or its designees will not void this Policy or any covered member's insurance if it would otherwise have been in effect. Such clerical error will not cause any member to become insured if such member was not otherwise eligible. Such clerical error will also not extend any covered member's coverage if such coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

MULTIPLE INTERNATIONAL COVERAGES. The Participating Sponsor certifies that the covered members are only covered under one international expatriate Policy offered by the Insurance Company. The Participating Sponsor certifies that a covered member cannot have coverage under another international expatriate Policy offered by the Insurance Company.

NON-COMPLIANCE WITH POLICY REQUIREMENTS. Any express or implied waiver by the Insurance Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Insurance Company to enforce any Policy provision will not be a waiver or amendment of that provision.

CIGNA GLOBAL INSURANCE COMPANY LIMITED
PO Box 155 Mill Court
La Charroterie
St. Peter Port, Guernsey GY1 4ET

GROUP POLICY

POLICYHOLDER: CIGNA GLOBAL WELLBEING SOLUTIONS

PARTICIPATING SPONSOR/GROUP: Louisiana Tech University

POLICY NUMBER: 10676A

POLICY EFFECTIVE DATE: September 1, 2025

POLICY ANNIVERSARY DATE: September 1

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

These materials are being made available electronically for your convenience. Should you have any questions regarding content, please feel free to contact Cigna. A printed document will be provided upon request.

By:

A handwritten signature in black ink, appearing to read "Jae Lay", with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

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SCHEDULE OF BENEFITS

Premium Due Date: The 1st day of each calendar month.

Classes of Eligible Members

Students: Each member identified as a student by the Participating Group.

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SCHEDULE OF BENEFITS

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Member must be in Active Service/Enrollment to be eligible for coverage. It will be extended by the number of days the Member is not in Active Service/Enrollment.

For Members eligible on or before the Policy Effective Date:	A period of time as determined by the Group

For Members eligible after the Policy Effective Date:	A period of time as determined by the Group

ACCIDENT INSURANCE BENEFITS

Member Benefits

Amount of Insurance	\$10,000

Age Based Reductions	Accident Insurance Benefits for a Member age 65 or older are payable as follows:
	Age 65-69 65% of Accident Insurance Benefits
	Age 70 and over 50% of Accident Insurance Benefits

ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

MEMBER

A member in one of the Classes of Eligible Members shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the Eligibility Waiting Period, if later.

Except as noted in the Reinstatement Provision, if a Member terminates coverage and later wishes to reapply, or if a former Member is rehired, a new Eligibility Waiting Period must be satisfied. A Member is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Members, but continues to be employed by the Participating Group, and within one year becomes a member of an eligible class.

EFFECTIVE DATE OF INSURANCE

A Member will be insured on the date he or she becomes eligible, if the Member is not required to contribute to the cost of this insurance.

If an eligible Member is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

TERMINATION OF INSURANCE

Coverage will end on the earliest of the following dates:

1. the date the Member is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date a Member is no longer in Active Service;
6. for a Member, the date the Participating Group cancels participation under the Policy.
7. the date the Member's medical insurance policy is terminated.

CONTINUATION OF INSURANCE

If a Member is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

ACCIDENT INSURANCE BENEFITS

The Insurance Company will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses, if a Member is insured under the Policy for Accident Insurance on the date of an Accident. If more than one loss results from the same Accident, the Insurance Company will pay only the largest Benefit Amount to which the Insured is entitled.

The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

Schedule of Losses	Benefit Amount
Life, or Two Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

ACCIDENT INSURANCE EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).
2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
4. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, or a similar air transport service of another country; an aircraft owned or leased by or for the Participating Group, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.
5. Injuries arising out of, or in the course of, any work for wage or profit.
6. Commission of a felony.
7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.
8. Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in St. Peter Port, Guernsey or to our agent. Notice should include the Participating Group's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Participating Group is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Participating Group if not permitted by applicable privacy laws.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

CLAIM PROVISIONS

(Continued)

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to \$1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary

The Insured may change the beneficiary at any time by giving written notice to the Participating Group or the Insurance Company. The beneficiary's consent is not required for this or any other change which the Insured may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Participating Group or the Insurance Company. When this form is received, it will take effect as of the date of the form. If the Insured dies before the form is received, the Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

CLAIM PROVISIONS

(Continued)

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the locale in which the Member lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

Physician/Patient Relationship

The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Relationship to Medical Insurance

This Policy is a rider to the medical insurance policy issued to the Policyholder by the Insurance Company. This Policy is valid only during such period as the medical insurance policy is in effect.

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or provincial law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Participating Group has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

ADMINISTRATIVE PROVISIONS

(Continued)

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Premium Exclusive of Indirect Taxes

All fees charged by the Insurance Company are exclusive of any applicable indirect taxes which are the liability of the Policyholder, including but not limited to value-added tax, goods and services tax, sales or use tax, or other similar taxes. If Insurance Company determines it is required to collect and remit any such taxes on the Policyholder's behalf, Insurance Company will include such charges in the manner and at the rate prescribed by law.

Reporting Requirements

The Participating Group must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium

The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Participating Group and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation

The Participating Group or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A Policy Grace Period of 90 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Participating Group is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Reinstatement of Insurance

Coverage may be reinstated without satisfying the Insurability Requirement, if a Member's insurance ends because he or she is on an unpaid leave of absence or has disenrolled from School and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

ADMINISTRATIVE PROVISIONS
(Continued)

APPEAL AND COMPLAINTS

Any claim appeal or complaint should in the first instance be sent to the Insurance Company at:

Cigna
Attn: Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

If the complaint is not resolved to your satisfaction, you may raise the complaint to the Channel Islands Financial Ombudsman Service at:

The Channel Islands Financial Ombudsman (CIFO)
P.O. Box 114
Jersey, Channel Islands
JE4 9QG
Telephone: +44 (0)1534 748610
Fax: +44 (0)1534 747629
Email: enquiries@ci-fo.org
Website www.ci-fo.org

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR MEMBER BENEFITS

Basic Accident Insurance

Rate included in the Medical Premium

GENERAL POLICY PROVISIONS

Entire Contract

The entire contract will be made up of the Policy, the application of the Participating Group, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability

All statements made by the Participating Group or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy. After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes

No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates

A certificate of insurance will be delivered to the Policyholder for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

GENERAL POLICY PROVISIONS

(Continued)

Male Pronoun

The male Pronoun as used herein will be deemed to include the female.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency

The Participating Group and Plan Administrator are agents of the Member for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

Compliance

The Insurance Company's products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service/Enrollment

If you are a Member, you are in Active Service / Enrollment with the Participating Group on the day you become actively enrolled as an international student studying outside your home country of permanent resident.

Injury

Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurance Company

The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured

A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Member

For eligibility purposes, you are a member if the following conditions are met.

1. You are actively enrolled as an international student studying abroad outside of your home country of permanent residence
2. You actively work for the Participating Group and are in one of the "Classes of Eligible Members."
3. You are member of the Participating Group who is insured under the Policy.

Participating Group

The term Participating Group means an educational institution participating in the Trust to which this policy is issued.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Member, a Member's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of a Member or spouse, or a person living in an Member's household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Participating Group in effect directly prior to the Policy Effective Date.

Sickness

Any physical or mental illness.

**GROUP AD&D
INSURANCE CERTIFICATE**

**Participating Sponsor/Group:
LOUISIANA TECH UNIVERSITY**

FOREWORD

AD&D insurance provides individuals and their families with financial protection. The AD&D Insurance Benefit described in this booklet will help secure your family's financial security in the event of your accident.

The need for accident insurance protection depends on individual circumstances and financial situations. This valuable coverage should add an extra dimension to your personal insurance portfolio.

In an effort to make your benefit program more comprehensive and responsive to your needs, your Participating Group is providing this insurance to you at no cost.

CIGNA GLOBAL INSURANCE COMPANY LIMITED

PO Box 155 Mill Court

La Charroterie

St. Peter Port, Guernsey GY1 4ET

**GROUP INSURANCE
CERTIFICATE**

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your Participating Group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your Participating Group or Cigna.

A handwritten signature in black ink, appearing to read "Jae Lay", with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

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SCHEDULE OF BENEFITS

Policy Effective Date: September 1, 2025

Policy Anniversary Date: September 1

Policy Number: 10676A

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active Members of the Participating Group.

Your Eligibility Waiting Period

If applicable, the Eligibility Waiting Period is the period of time you must wait to be eligible for coverage as determined by the Participating Group.

ACCIDENT INSURANCE BENEFITS

Member Benefits

Amount of Insurance \$10,000

Age Based Reductions

If you are age 65 or older, your Accident Insurance Benefits are payable as follows:

Age 65 to 69	65% of Accident Insurance Benefits
Age 70 and over	50% of Accident Insurance Benefits

WHO IS ELIGIBLE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law or sanctions rules will not be considered eligible under this plan.

MEMBER

A Member in one of the Classes of Eligible Members shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the Eligibility Waiting Period if applicable, if later.

Except as noted in the Reinstatement Provision, if a Member terminates coverage and later wishes to reapply, or if a former Member is rehired/reenrolled, a new Eligibility Waiting Period must be satisfied. A Member is not required to satisfy a new Eligibility Waiting Period, if insurance ends because he or she is no longer in a Class of Eligible Members, but continues to be employed by the Participating Group, and within one year becomes a member of an eligible class.

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are not in Active Service/Enrollment on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for a Member, the date the Participating Group cancels participation under the Policy; and
7. the date your medical insurance policy is terminated.

ACCIDENT INSURANCE BENEFITS

If you are a Member and insured under the Policy for Accident Insurance on the date of an Accident, we will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses. If more than one loss results from the same Accident, we will pay only the largest Benefit Amount to which you are entitled. The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

Schedule of Losses	Benefit Amount
Life, or Two Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand.....	25%

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

WHAT IS NOT COVERED

ACCIDENT EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).
2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
4. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, or a similar air transport service of another country; an aircraft owned or leased by or for the Participating Group, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.
5. Injuries arising out of, or in the course of, any work for wage or profit.
6. Commission of a felony.
7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.
8. Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in St. Peter Port, Guernsey or to our agent. Notice should include the Participating Group's name, the Policy Number and the claimant's name and address.

Claim Forms

When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Participating Group is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Participating Group in these areas is confidential and may not be used or released by the Participating Group if not permitted by applicable privacy laws.

Proof of Loss

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

CLAIM PROVISIONS

(Continued)

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Change of Beneficiary

You may change your beneficiary at any time by giving written notice to the Participating Group or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Participating Group or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

CLAIM PROVISIONS

(Continued)

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the locale in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

Physician/Patient Relationship

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Reinstatement of Insurance

Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Service.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.

1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

GENERAL PROVISIONS

Incontestability

All statements made by the Participating Group or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age

If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits

We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

GENERAL PROVISIONS
(Continued)

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Active Service/Enrollment

If you are a Member, you are in Active Service / Enrollment with the Participating Group on the day you become actively enrolled as an international student studying outside your home country of permanent resident.

Injury

Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

Insurance Company

The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Member

For eligibility purposes, you are a member if the following conditions are met.

1. You are actively enrolled as an international student studying abroad outside of your home country of permanent residence
2. You actively work for the Participating Group and are in one of the "Classes of Eligible Members."
3. You are member of the Participating Group who is insured under the Policy.

Participating Group

The term Participating Group means an educational institution participating in the Trust to which this policy is issued.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Participating Group and in effect directly prior to the Policy Effective Date.

Sickness

The term Sickness means a physical or mental illness.

Appeal Procedure for Denied Claims

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

When You Have an Appeal or Complaint

If you have questions, disagree with the determination of a claim, or have a complaint, you may contact Cigna at the address indicated below. A written request for a claim review must be sent in writing to:

Cigna
Attn: Appeals & Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For a claim review, you should state the reason(s) why you feel your claim should have been approved. Send a copy of the denial along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

It is important to include your Name, Group Number, Member/Patient ID Number, Name of the patient and relationship, and "Attention: Appeals" on all supporting documents. You are entitled to receive free upon request access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the final decision in a timely manner, as described in your plan materials.

Appeal Procedure for Denied Claims (Continued)

If you are still not satisfied with our final decision to your complaint or appeal, you can refer your complaint or appeal to the Channel Islands Financial Ombudsman Service at the address below:

The Channel Islands Financial Ombudsman (CIFO)

PO Box 114

Jersey, Channel Islands

JE4 9QG

Telephone: +44 (0)1534 748610

Fax: +44 (0)1534 747629

Email: enquiries@ci-fo.org

Website www.ci-fo.org

UNDERWRITTEN BY:
CIGNA GLOBAL INSURANCE COMPANY LIMITED
a Cigna company

11/2025



Addendum #1 - Attachment #4

Bid Number:	50012-563-26	Bid Title:	International Student Health Insurance

GROUP INBOUND TRAVEL INSURANCE POLICY

POLICYHOLDER: Fairmont Specialty Trust

POLICYHOLDER ADDRESS: ITA Global Trust, LTD
Suite 4210, 2nd Floor Canella Court,
48 Market St,
Camana Bay
PO Box 32203,
Grand Cayman KY1-1208,
Cayman Islands

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: August 29, 2023

EXPIRATION DATE: August 28, 2024

UMR: B115R180022

The Policy is a legal contract between the Policyholder and Crum & Forster SPC for and on behalf of ITI SP (herein referenced as “the Company”).

This Policy is issued by Crum & Forster SPC for and on behalf of ITI SP to the Fairmont Specialty Trust located in the Cayman Islands.

This Policy is not subject to U.S. jurisdiction.

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy. The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS LIMITED BENEFIT SHORT DURATION COVERAGE.

READ IT CAREFULLY.

THE POLICY IS NOT RENEWABLE.

TABLE OF CONTENTS

The following provisions appear within the Policy in the following order:

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SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: 8/01/2023

POLICY NUMBER: CC008744

UMR: B115R180022

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

POLICY PERIOD: August 29, 2023 through August 28, 2024

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Plan Participant at the same time.

Class 1: Non-United States Citizens traveling outside their Home Country having his or her true, fixed and permanent home and principal establishment outside of the United States, and who holds a current and valid passport.

Class 2: Spouses of the above eligible Class, who is considered to be a covered Class and whose Application has been accepted by the Company.

Natural or legally adopted Dependent unmarried children of an above eligible Class under 18 years of age who is considered to be a covered Class and whose Application has been accepted by the Company.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum: \$10,000

Class 2 Principal Sum: \$5,000 Spouse / \$1,000 Child

Time Period for Loss: 365 days

Loss of:

Benefit:

(Percentage of Principal Sum)

Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

Policy Term Maximum for all Injury and Sickness Medical Expenses:	\$250,000
Deductible Per Plan Participant Per Policy Term:	\$200
Deductible at Student Health Center:	\$0
Initial Treatment Period:	90 Days from the date of Injury or Sickness
Out-of-Pocket Maximum Per Plan Participant Per Policy Term:	\$5,000
Coinsurance:	Network Provider: 100% of the Preferred Allowance (PA) Non-Network Provider: 80% of Usual, Reasonable & Customary (URC) Charges
Terms of Payment	Full Excess

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant basis.

After the Deductible has been satisfied, benefits will be paid as listed below for the Provider selected.

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Hospital Room & Board Benefit	100% of PA, subject to a \$50 copay per admission	80% of URC
Intensive Care/Cardiac Care Unit Benefit	100% of PA	80% of URC
Hospital Miscellaneous Expense Benefit	100% of PA	80% of URC

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Surgeon (In or Outpatient) Benefits	100% of PA	80% of URC
Assistant Surgeon Benefit	100% of PA	80% of URC
Pre-Admission Testing Benefit	100% of PA	80% of URC
Anesthesia Benefit	100% of PA	80% of URC
Day Surgery Miscellaneous Benefit	100% of PA	80% of URC
Diagnostic X-Ray and Lab Benefit	100% of PA	80% of URC
Ambulance Benefit	100% of PA	80% of URC
Physician Visit Benefit (Inpatient)	100% of PA	80% of URC
Physician Visit Benefit (Outpatient)	100% of PA, subject to a \$25 copay	80% of URC
Consultant Physician Benefit	100% of PA, subject to a \$25 copay	80% of URC
Radiation/Chemotherapy Benefit	100% of PA	80% of URC
Emergency Room Benefit	100% of PA, subject to a \$150 copay <i>(waived if admitted)</i>	80% of URC
Extension of Accident and Sickness Medical Benefits	100% of PA	80% of URC
Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness	Covered as any other Sickness

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Wellness Medical Benefit (<i>Up to \$250 per policy term</i>)	100% of PA	80% of URC
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense	100% of PA	80% of URC
Out-Patient Expense	100% of PA, subject to \$25 copay for Physician Office Visits	80% of URC
Emergency Dental Expense Benefit	100% of PA	80% of URC
Physiotherapy Expense Benefit - Inpatient	100% of PA	80% of URC
Physiotherapy Expense Benefit - Outpatient	100% of PA, subject to a \$25 copay per visit	80% of URC
Durable Medical Equipment Expense Benefit	100% of PA	80% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense up to \$100,000	
Emergency Medical Repatriation Expense Benefit	Student - 100% of actual expense up to \$25,000 Spouse & Child: 100% of actual expense up to \$50,000	
PRESCRIPTION DRUG EXPENSE BENEFIT	Wellfleet Rx/ESI Network Provider	Non-Network Provider:
Covered Percentage:	75% of the Preferred Allowance based on a 30-day supply per prescription	Not Covered
Contraceptive Drugs	Based on Above	Not Covered

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or

Co-pay amount.

- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Policy the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

- 1) Causes Injury to one or more Plan Participants; and
- 2) Occurs while coverage is in effect for the Plan Participant.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Benefit Period means the period of time from the date of the Accident causing the Injury or Sickness for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Caregiver means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter; childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

Child means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region.

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means Crum & Forster SPC for and on behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;

Complications of Pregnancy will not include:

- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is *non-elective*. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Contraceptive Drugs include oral contraceptives (combined estrogen and progestin and progestin-only), NuvaRing, Depo Vera and Ortho Evra.

Co-Payment means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Plan Participant and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an accidental death, dismemberment, Sickness or other Injury covered under the Policy and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Policy. It applies separately to each Plan Participant.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Dependent means a Plan Participant's:

- 1) lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Union Partner.
- 2) unmarried Children under age 18.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining

employment by reason of mental or physical handicap that occurred before age 18. Proof of such dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Elective Treatment and Procedures means any Medical Treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury or Sickness. Eligible Expenses must be incurred while the Policy is in force.

Emergency/Emergency Treatment means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Expatriate means (1) a person working or living outside their country of citizenship; (2) a person working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in the United States.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- 1) Group or blanket insurance, whether on an insured or self-funded basis;
- 2) Hospital or medical service organizations on a group basis;
- 3) Health Maintenance Organizations on a group basis.
- 4) Group labor management plans;
- 5) Employee benefit organization plan;
- 6) Professional association plans on a group basis; or
- 7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- 8) Automobile no-fault coverage (unless prohibited by law).

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, holds a current and valid passport, and to which he or she has the intention of returning.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

Host Country means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, and holds a current and valid passport.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant's spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Immunizations Include: flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, meningococcal; only as recommended by the U.S. Centers for Disease Control and Prevention.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant's coverage under the Policy, while the Policy is in force as

to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient means a Plan Participant who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Policy.

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

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Master Application means the Application for the Master Policy.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

- 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
- 2) Prescribed or ordered by a Physician or furnished by a Hospital;
- 3) Performed in the least costly setting required by the condition;
- 4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the

medical care or treatment is rendered to a Plan Participant.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Natural Teeth means the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Participating Organization means any organization which elects to offer coverage by completing a Participation Agreement and that has been approved by the Company to sponsor coverage under the Policy.

Participation Agreement means the agreement completed by a Participating Organization for insurance under the Master Policy.

Permanent Residence means the country where an Plan Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

Physician means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a Non-United States Citizen traveling outside their Home Country, has his or her true, fixed and permanent home and principal establishment outside of the United States, holds a current and valid passport, and for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

Policy means this document, the Master Application of the Policyholder and the Participating Organization and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Policy Period means the period of time following the Policy's Effective Date, as shown on the Schedule of Benefits.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 6-month period immediately prior to the date the Plan Participant's coverage is effective for which the Plan Participant: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6-month period before coverage is effective under the Plan Participant's Plan.

Pregnancy means the physical condition of being pregnant, including Complication of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

- 1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
- 2) A free standing facility.

Service Provider means a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means illness or disease which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Partner.

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

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Usual, Reasonable and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;

- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

We, Our, Us means Crum & Forster SPC for and on behalf of ITI SP.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

A Plan Participant Person's Dependent(s), as applicable, are eligible on the latest of the date:

- 1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or
- 2) the date the person becomes a Dependent; or
- 3) the next Annual Open Enrollment (if applicable) following the date the person becomes a Dependent if the Newborn Children Coverage, Newborn Adopted Children Coverage or Adopted Children Coverage provisions do not apply.

If the Plan Participant is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Policy. In no event will a Dependent be eligible if the Plan Participant is not eligible.

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.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder and will continue in force until either a) the Policy Expiration Date stated in the Schedule; or b) the Policy is cancelled pursuant to the terms of the Policy.

Plan Participant's Effective Date for Coverage:

A Person will become a Plan Participant under the Policy, provided proper premium payment is made, on the latest of:

- 1) The Effective Date of the Policy; or
- 2) The date the Company receives a completed application or enrollment form; or
- 3) The day the Plan Participant becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form; or
- 4) The moment the Plan Participant departs their Home Country airspace; or
- 5) The Date the Company approves the Application; or
- 6) The Date requested by the Participating Organization.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31 day period.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order granting You temporary custody of the child, whichever comes first. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate upon the expiration of the initial 31-day period.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

- 1) The Policy Expiration Date shown in the Policy; or
- 2) The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

- 1) The date the Participating Organization no longer meets the definition of a Participating Organization;
- 2) The date the Participating Organization loses its entity by means of dissolution, merger, or otherwise;
- 3) The date the Participating Organization is eliminated as a Participating Organization by an amendment to or change in the Policy;
- 4) The date ending the Coverage Month for which the last premium payment is made for the Participating Organization's insurance;
- 5) The last day of a Coverage Month, provided the Company has given the Participating Organization at least 30-calendar days prior written notice; and
- 6) The last day of a Coverage Month, if the Participating Organization has given the Company at least 30-calendar days prior written notice.

Termination of the Policy, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Plan Participant's Termination Date for Coverage:

Insurance for a Plan Participant will end on the earliest of:

- 1) The date the Plan Participant is no longer in an Eligible Class; or
- 2) The date the Plan Participant returns to his or her Home Country; or
- 3) The expiration of 364 days from the Effective Date of Coverage; or
- 4) The date shown on the Evidence of Coverage issued by the Company; or
- 5) The date the Plan Participant becomes a permanent resident of the United States; or
- 6) The date the Plan Participant reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a) The date the premium is fully earned; or
 - b) The Expiration Date of the Policy.

This does not include Reserve or National Guard duty for training;

- 7) The end of the period for which the last premium contribution is made; or
- 8) The date the Policy is terminated; or
- 9) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or
- 10) The date the Plan Participant's participation in the Program terminates; or
- 11) The date the Plan Participant's Trip is completed; or
- 12) The date the Participating Organization is no longer eligible to sponsor coverage under the Policy; or
- 13) The expiration date of the term of coverage, requested by the Participating Organization; or
- 14) The end of the Benefit Period shown in the Schedule of Benefits.

Dependent's Termination Date

A Dependent's coverage under the Policy ends on the earliest of:

- 1) The date the Policy terminates; or
- 2) The date the Plan Participant's coverage ends; or

- 3) The date the Dependent is no longer a Dependent; or
- 4) The last day of the period for which premiums have been paid
- 5) The end of the Benefit Period shown in the Schedule of Benefits.

PREMIUM PROVISIONS

Premiums:

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Premiums due for the Policy will be remitted to Us by an officer of the Policyholder or by any other person designated by the Policyholder to remit such premiums. Premium is due at the time of enrollment.

Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

The Company has the right to rely upon the accuracy of the Participating Organization's calculations and to require the Participating Organization to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Participating Organization will pay the additional premium or apply the premium credit at the next premium due date.

Grace Period:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Participating Organization pays all of the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in the factors bearing on the risk assumed.
- 4) A misrepresentation in the information relied on in establishing the rate for the Policy
- 5) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Participating Organization submits written application to the Company, the Company accepts the application and the Participating Organization makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside of the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as a Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Policy to all Plan Participants who suffer a Covered Loss which:

- 1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
- 2) Occurs while the person is a Plan Participant under the Policy.

Terms of Payment for Benefits:

Full Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, Co-Payment, and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury or Sickness:

- 1) While the person is a Plan Participant under the Policy; or
- 2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF BENEFITS

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum:	\$10,000
Class 2 Principal Sum:	\$10,000
Time Period for Loss:	365 days

Loss of:

Loss of Life
Loss of Both Hands
Loss of Both Feet

Benefit:

(Percentage of Principal Sum)

100%
100%
100%

Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident or Injury and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident or Injury and Sickness Medical Expense Benefits are only payable:

- 1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
- 3) for Eligible Expenses incurred within 30 days after the date of the Eligible Expense.

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

- 1) **Hospital Admission Expenses:** Charges for each hospital admission.
- 2) **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 7 days of the testing.
- 3) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
- 4) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.
- 5) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- 6) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care /Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

- 1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
- 2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

ASSISTANT SURGEON BENEFIT

If, in connection with such operation, a Plan Participant requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing).

ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Eligible expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Eligible expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

- 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
- 2) the drug is approved by the FDA for use in antineoplastic therapy;
- 3) the drug is used as part of an antineoplastic drug regimen;
- 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
- 5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Injury or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people Emergency Treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

If a Student seeks treatment at the Student Health Center and treatment is not possible at the Student Health Center and a student is referred to the ER, co-payments for the Emergency Room will be half of the scheduled amount.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 30 days, or the maximum benefit has been paid, whichever occurs first.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses an Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care is not necessary for the Plan Participant or her newborn Child provided the following are met:

- 1) In the opinion of the Plan Participant Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
 - a) The antepartum, intrapartum, postpartum course of the mother and infant;
 - b) The gestational stage, birth weight, and clinical condition of the infant;
 - c) The demonstrated ability of the mother to care for the infant after discharge; and
 - d) The availability of post discharge follow up to verify the condition of the infant after discharge; and
2. One (1) at-home post-delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
 - a) Parent education;
 - b) Assistance in training in breast or bottle feeding; and
 - c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

WELLNESS MEDICAL EXPENSE BENEFIT

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1. Routine physical examinations: per Plan term which includes, one routine physical examination, laboratory tests, x-rays and any other medical expense related to the examination.

2. Preventive medical attention: includes, annual Screening Mammogram for women; an annual cervical screening for women; a gynecological exam for women; Immunizations; Contraceptive Devices; Colorectal screening for adults over 50, an annual standard prostate diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

- a) Schizophrenia;
- b) Schizoaffective disorder;
- c) bipolar affective disorder;
- d) major depressive disorder;
- e) specific obsessive-compulsive disorder;
- f) delusional disorders;
- g) obsessive compulsive disorders;
- h) binge eating, anorexia and bulimia; and

- i) panic disorder.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT ALCOHOL and DRUG SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

- a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
- b) managing withdrawal symptoms; and
- c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to sustaining an Injury to natural teeth.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the

Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means** charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist, up to up to the maximum amount shown in the Schedule of Benefits per day for the Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment which includes braces and appliances means medical equipment that:

- 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
- 2) can withstand long-term repeated use without replacement;
- 3) is not useful in the absence of an Injury or Sickness; and
- 4) can be used in the home without medical supervision.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

- 1) **Emergency Medical Evacuation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
- 2) **Medical Repatriation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your

primary place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:

- a) one-way Economy Transportation;
 - b) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing [and considered necessary by the authorized travel assistance company; or
 - c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.
- 3) Return of Remains: In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, co-payment, and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

- 1) Under Federal law may only be dispensed by written prescription; and
- 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

- 1) On or after the Plan Participant's Effective Date; and
- 2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

EXCLUSIONS

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

- 1) War or any act of war, declared or undeclared;
- 2) Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
- 3) Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 4) Voluntary, active participation in a riot or insurrection;
- 5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and

expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;

- 6) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 7) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
- 8) Charges which are in excess of Usual, Reasonable and Customary charges;
- 9) Charges that are not Medically Necessary;
- 10) Charges provided at no cost to the Plan Participant;
- 11) Expenses incurred for treatment while in Your Home Country;
- 12) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 13) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
- 14) Duplicate services actually provided by both a certified nurse midwife and Physician;
- 15) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
- 16) Drug, treatment or procedure that either promotes conception, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 17) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 18) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;
- 19) Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
- 20) Weak, strained or flat feet, corns, calluses, or toenails;
- 21) Private-duty nursing services;
- 22) Expenses payable under any prior policy which was in force for the person making the claim;
- 23) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 24) Pre-existing conditions; however a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization;
- 25) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; motorcycle riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; solo diving; snorkeling; snow skiing; spelunking; parasailing; white water rafting; surfing and snow boarding.
- 26) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 27) Rest cures or custodial care;
- 28) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);

- 29) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
- a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
 - e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f) An ultra light, hang-gliding, parachuting or bungie-cord jumping;
- Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
- 30) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
- 31) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Plan Participant's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30-day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90-day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:

All claims for benefits under the Policy must be submitted to Us no more than 90 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to His/Her beneficiary as described in the Designation and Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to His beneficiary or to His estate. All other benefits, unless specifically stated otherwise, will be paid to a Plan Participant.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

- 1) Beneficiaries designated in writing by the Plan Participant for the Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Plan Participant's lawful spouse, if not legally separated or divorced, Domestic Partner or Civil Union Partner;
 - b) a Plan Participant's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Plan Participant has or had legal guardianship (proof will be required); or
 - c) a Plan Participant's parents, whether natural, step or adoptive; or
 - d) a Plan Participant's Sisters or Brothers, otherwise.
- 4) The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Plan Participant's estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error or
- 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

- (1) Received in a covered Accident; and

(2) Which are covered under:

- (a) workers' compensation or similar statutory remedies available under law; or
- b) Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

“Recovery” means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

LEGAL ACTIONS:

No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

COMPLAINTS

In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at [\[Administrator/Producer contact information.\]](#)

Data Protection

Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the application of the Policyholder, a copy of which is attached, endorsements, riders, and the application or participation agreement with the Participating Organization and attached papers constitute the entire contract between the parties. If an application of a Plan Participant is required, the application of any Plan Participant, at Our option, may also be made a part of this contract.

All statements made by the Policyholder, Participating Organization, or by a Plan Participant are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Plan Participant's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Plan Participant's insurance under the Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under the Policy. Examination may occur at any reasonable time up to the later of:

- (1) The two year period after the expiration of the Policyholder's coverage; or
- (2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

- (1) The names of all Plan Participants on the Effective Date of the Policy;
- (2) The names of all persons who are Plan Participant after the Effective Date of the Policy;
- (3) The names of those persons whose insurance has terminated; and
- (4) Additional information required as agreed to by Us and the Policyholder.

EVIDENCE OF COVERAGE:

An Evidence of Coverage of insurance will be delivered to the Participating Organization for delivery to each Plan Participant. Each Evidence of Coverage will list the benefits, conditions and limits of the Evidence of Coverage. It will state to whom the benefits will be paid.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

OTHER COVERAGE WITH US:

At any one time each Plan Participant may have only one Evidence of Coverage issued by Us having coverage similar to that described in the Policy. If we find He has more than one such Evidence of Coverage, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Evidence of Coverages for concurrent periods of coverage.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Plan Participants under the Policy.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

Addendum #1 - Attachment #5

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

GROUP INBOUND TRAVEL INSURANCE POLICY

POLICYHOLDER: Fairmont Specialty Trust

POLICYHOLDER ADDRESS: ITA Global Trust, LTD
Suite 4210, 2nd Floor Canella Court,
48 Market St,
Camana Bay
PO Box 32203,
Grand Cayman KY1-1208,
Cayman Islands

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: September 4, 2024

EXPIRATION DATE: September 3, 2025

UMR: B115R180022

The Policy is a legal contract between the Policyholder and Crum & Forster SPC for and on behalf of ITI SP (herein referenced as “the Company”).

This Policy is issued by Crum & Forster SPC for and on behalf of ITI SP to the Fairmont Specialty Trust located in the Cayman Islands.

This Policy is not subject to U.S. jurisdiction.

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy. The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS LIMITED BENEFIT SHORT DURATION COVERAGE.

READ IT CAREFULLY.

THE POLICY IS NOT RENEWABLE.

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SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: 9/04/2024

POLICY NUMBER: CC008771

UMR: B115R180022

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

POLICY PERIOD: September 4, 2024 through September 3, 2025

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Plan Participant at the same time.

Class 1: Non-United States Citizens traveling outside their Home Country having his or her true, fixed and permanent home and principal establishment outside of the United States, and who holds a current and valid passport.

Class 2: Spouses of the above eligible Class, who is considered to be a covered Class and whose Application has been accepted by the Company.

Natural or legally adopted Dependent unmarried children of an above eligible Class under 18 years of age who is considered to be a covered Class and whose Application has been accepted by the Company.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum: \$10,000

Class 2 Principal Sum: \$5,000 Spouse / \$1,000 Child

Time Period for Loss: 365 days

Loss of:

Benefit:

(Percentage of Principal Sum)

Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

Policy Term Maximum for all Injury and Sickness Medical Expenses:	\$250,000
Deductible Per Plan Participant Per Policy Term:	\$200
Deductible at Student Health Center:	\$0
Initial Treatment Period:	90 Days from the date of Injury or Sickness
Out-of-Pocket Maximum Per Plan Participant Per Policy Term:	\$5,000
Coinsurance:	Network Provider: 100% of the Preferred Allowance (PA) Non-Network Provider: 80% of Usual, Reasonable & Customary (URC) Charges
Terms of Payment	Full Excess

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant basis.

After the Deductible has been satisfied, benefits will be paid as listed below for the Provider selected.

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Hospital Room & Board Benefit	100% of PA, subject to a \$50 copay per admission	80% of URC
Intensive Care/Cardiac Care Unit Benefit	100% of PA	80% of URC
Hospital Miscellaneous Expense Benefit	100% of PA	80% of URC

BENEFIT COVERAGE		BENEFIT AMOUNT	
		In-Network Provider Benefit	Out-of-Network Provider Benefit
Surgeon (In or Outpatient) Benefits		100% of PA	80% of URC
Assistant Surgeon Benefit		100% of PA	80% of URC
Pre-Admission Testing Benefit		100% of PA	80% of URC
Anesthesia Benefit		100% of PA	80% of URC
Day Surgery Miscellaneous Benefit		100% of PA	80% of URC
Diagnostic X-Ray and Lab Benefit		100% of PA	80% of URC
Ambulance Benefit		100% of PA	80% of URC
Physician Visit Benefit (Inpatient)		100% of PA	80% of URC
Physician Visit Benefit (Outpatient)		100% of PA, subject to a \$25 copay	80% of URC
Consultant Physician Benefit		100% of PA, subject to a \$25 copay	80% of URC
Radiation/Chemotherapy Benefit		100% of PA	80% of URC
Emergency Room Benefit		100% of PA, subject to a \$150 copay (<i>waived if admitted</i>)	80% of URC
Extension of Accident and Sickness Medical Benefits		100% of PA	80% of URC
Maternity and Pre-Natal Care Expense Benefit		Covered as any other Sickness	Covered as any other Sickness

BENEFIT COVERAGE		BENEFIT AMOUNT	
		In-Network Provider Benefit	Out-of-Network Provider Benefit
Wellness Medical Benefit (<i>Up to \$250 per policy term</i>)		100% of PA	80% of URC
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT			
	In-Patient Expense	100% of PA	80% of URC
	Out-Patient Expense	100% of PA, subject to \$25 copay for Physician Office Visits	80% of URC
Emergency Dental Expense Benefit		100% of PA	80% of URC
Physiotherapy Expense Benefit - Inpatient		100% of PA	80% of URC
Physiotherapy Expense Benefit - Outpatient		100% of PA, subject to a \$25 copay per visit	80% of URC
Durable Medical Equipment Expense Benefit		100% of PA	80% of URC
Emergency Medical Evacuation Expense Benefit		100% of actual expense up to \$100,000	
Emergency Medical Repatriation Expense Benefit		Student - 100% of actual expense up to \$25,000 Spouse & Child: 100% of actual expense up to \$50,000	
PRESCRIPTION DRUG EXPENSE BENEFIT		Wellfleet Rx/ESI Network Provider	Non-Network Provider:
	Covered Percentage:	75% of the Preferred Allowance based on a 30-day supply per prescription	Not Covered
Contraceptive Drugs		Based on Above	Not Covered

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-pay amount.
- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Policy the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

- 1) Causes Injury to one or more Plan Participants; and
- 2) Occurs while coverage is in effect for the Plan Participant.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Benefit Period means the period of time from the date of the Accident causing the Injury or Sickness for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Caregiver means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter, childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

Child means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region.

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means Crum & Forster SPC for and on behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;

Complications of Pregnancy will not include:

- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is *non-elective*. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Contraceptive Drugs include oral contraceptives (combined estrogen and progestin and progestin-only), NuvaRing, Depo Vera and Ortho Evra.

Co-Payment means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Plan Participant and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an accidental death, dismemberment, Sickness or other Injury covered under the Policy and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Policy. It applies separately to each Plan Participant.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Dependent means a Plan Participant's:

- 1) lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Union Partner.
- 2) unmarried Children under age 18.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining employment by reason of mental or physical handicap that occurred before age 18. Proof of such dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Elective Treatment and Procedures means any Medical Treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury or Sickness. Eligible Expenses must be incurred while the Policy is in force.

Emergency/Emergency Treatment means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or

- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Expatriate means (1) a person working or living outside their country of citizenship; (2) a person working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in the United States.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- 1) Group or blanket insurance, whether on an insured or self-funded basis;
- 2) Hospital or medical service organizations on a group basis;
- 3) Health Maintenance Organizations on a group basis.
- 4) Group labor management plans;
- 5) Employee benefit organization plan;
- 6) Professional association plans on a group basis; or
- 7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- 8) Automobile no-fault coverage (unless prohibited by law).

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, holds a current and valid passport, and to which he or she has the intention of returning.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

“Daily Living Services” are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person’s care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

Host Country means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, and holds a current and valid passport.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant’s spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren)), brother, sister, step-Child(ren), grandchild(ren), or in-laws). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Immunizations Include: flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, meningococcal; only as recommended by the U.S. Centers for Disease Control and Prevention.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant's coverage under the Policy, while the Policy is in force as to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient means a Plan Participant who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Policy.

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

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Master Application means the Application for the Master Policy.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

- 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
- 2) Prescribed or ordered by a Physician or furnished by a Hospital;
- 3) Performed in the least costly setting required by the condition;
- 4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare

Financing Administration Medicare Coverage Issues Manual; or

- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to a Plan Participant.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Natural Teeth means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Participating Organization means any organization which elects to offer coverage by completing a Participation Agreement and that has been approved by the Company to sponsor coverage under the Policy.

Participation Agreement means the agreement completed by a Participating Organization for insurance under the Master Policy.

Permanent Residence means the country where an Plan Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

Physician means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a Non-United States Citizen traveling outside their Home Country, has his or her true, fixed and permanent home and principal establishment outside of the United States, holds a current and valid passport, and for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

Policy means this document, the Master Application of the Policyholder and the Participating Organization and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Policy Period means the period of time following the Policy's Effective Date, as shown on the Schedule of Benefits.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 6-month period immediately prior to the date the Plan Participant's coverage is effective for which the Plan Participant: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6-month period before coverage is effective under the Plan Participant's Plan.

Pregnancy means the physical condition of being pregnant, including Complication of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

- 1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
- 2) A free standing facility.

Service Provider means a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means illness or disease which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Partner.

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

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Usual, Reasonable and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

We, Our, Us means Crum & Forster SPC for and on behalf of ITI SP.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

A Plan Participant Person's Dependent(s), as applicable, are eligible on the latest of the date:

- 1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or
- 2) the date the person becomes a Dependent; or
- 3) the next Annual Open Enrollment (if applicable) following the date the person becomes a Dependent if the Newborn Children Coverage, Newborn Adopted Children Coverage or Adopted Children Coverage provisions do not apply.

If the Plan Participant is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Policy. In no event will a Dependent be eligible if the Plan Participant is not eligible.

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.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder and will continue in force until either a) the Policy Expiration Date stated in the Schedule; or b) the Policy is cancelled pursuant to the terms of the Policy.

Plan Participant's Effective Date for Coverage:

A Person will become a Plan Participant under the Policy, provided proper premium payment is made, on the latest of:

- 1) The Effective Date of the Policy; or
- 2) The date the Company receives a completed application or enrollment form; or
- 3) The day the Plan Participant becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form; or
- 4) The moment the Plan Participant departs their Home Country airspace; or
- 5) The Date the Company approves the Application; or
- 6) The Date requested by the Participating Organization.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31 day period.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order granting You temporary custody of the child, whichever comes first. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate upon the expiration of the initial 31-day period.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

- 1) The Policy Expiration Date shown in the Policy; or
- 2) The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

- 1) The date the Participating Organization no longer meets the definition of a Participating Organization;
- 2) The date the Participating Organization loses its entity by means of dissolution, merger, or otherwise;
- 3) The date the Participating Organization is eliminated as a Participating Organization by an amendment to or change in the Policy;
- 4) The date ending the Coverage Month for which the last premium payment is made for the Participating Organization's insurance;
- 5) The last day of a Coverage Month, provided the Company has given the Participating Organization at least 30-calendar days prior written notice; and
- 6) The last day of a Coverage Month, if the Participating Organization has given the Company at least 30-calendar days prior written notice.

Termination of the Policy, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Plan Participant's Termination Date for Coverage:

Insurance for a Plan Participant will end on the earliest of:

- 1) The date the Plan Participant is no longer in an Eligible Class; or
- 2) The date the Plan Participant returns to his or her Home Country; or
- 3) The expiration of 364 days from the Effective Date of Coverage; or
- 4) The date shown on the Evidence of Coverage issued by the Company; or
- 5) The date the Plan Participant becomes a permanent resident of the United States; or
- 6) The date the Plan Participant reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a) The date the premium is fully earned; or
 - b) The Expiration Date of the Policy.

This does not include Reserve or National Guard duty for training;

- 7) The end of the period for which the last premium contribution is made; or
- 8) The date the Policy is terminated; or
- 9) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or
- 10) The date the Plan Participant's participation in the Program terminates; or
- 11) The date the Plan Participant's Trip is completed; or
- 12) The date the Participating Organization is no longer eligible to sponsor coverage under the Policy;
or
- 13) The expiration date of the term of coverage, requested by the Participating Organization; or
- 14) The end of the Benefit Period shown in the Schedule of Benefits.

Dependent's Termination Date

A Dependent's coverage under the Policy ends on the earliest of:

- 1) The date the Policy terminates; or
- 2) The date the Plan Participant's coverage ends; or
- 3) The date the Dependent is no longer a Dependent; or
- 4) The last day of the period for which premiums have been paid
- 5) The end of the Benefit Period shown in the Schedule of Benefits.

PREMIUM PROVISIONS**Premiums:**

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Premiums due for the Policy will be remitted to Us by an officer of the Policyholder or by any other person designated by the Policyholder to remit such premiums. Premium is due at the time of enrollment.

Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

The Company has the right to rely upon the accuracy of the Participating Organization's calculations and to require the Participating Organization to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Participating Organization will pay the additional premium or apply the premium credit at the next premium due date.

Grace Period:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Participating Organization pays all of the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in the factors bearing on the risk assumed.
- 4) A misrepresentation in the information relied on in establishing the rate for the Policy
- 5) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Participating Organization submits written application to the Company, the Company accepts the application and the Participating Organization makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside of the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as a Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Policy to all Plan Participants who suffer a Covered Loss which:

- 1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
- 2) Occurs while the person is a Plan Participant under the Policy.

Terms of Payment for Benefits:

Full Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, Co-Payment, and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury or Sickness:

- 1) While the person is a Plan Participant under the Policy; or
- 2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF BENEFITS

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum: \$10,000

Class 2 Principal Sum: \$10,000

Time Period for Loss: 365 days

<u>Loss of:</u>	<u>Benefit:</u> <u>(Percentage of Principal Sum)</u>
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident or Injury and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident or Injury and Sickness Medical Expense Benefits are only payable:

- 1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
- 3) for Eligible Expenses incurred within 30 days after the date of the Eligible Expense.

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

- 1) **Hospital Admission Expenses:** Charges for each hospital admission.
- 2) **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 7 days of the testing.
- 3) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
- 4) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three

days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.

- 5) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- 6) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care /Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

- 1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
- 2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

ASSISTANT SURGEON BENEFIT

If, in connection with such operation, a Plan Participant requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing).

ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Eligible expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Eligible expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

- 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
- 2) the drug is approved by the FDA for use in antineoplastic therapy;
- 3) the drug is used as part of an antineoplastic drug regimen;
- 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
- 5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Injury or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people Emergency Treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

If a Student seeks treatment at the Student Health Center and treatment is not possible at the Student Health Center and a student is referred to the ER, co-payments for the Emergency Room will be half of the scheduled amount.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 30 days, or the maximum benefit has been paid, whichever occurs first.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses an Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care is not necessary for the Plan Participant or her newborn Child provided the following are met:

- 1) In the opinion of the Plan Participant Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
 - a) The antepartum, intrapartum, postpartum course of the mother and infant;
 - b) The gestational stage, birth weight, and clinical condition of the infant;
 - c) The demonstrated ability of the mother to care for the infant after discharge; and
 - d) The availability of post discharge follow up to verify the condition of the infant after discharge; and
2. One (1) at-home post-delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
 - a) Parent education;
 - b) Assistance in training in breast or bottle feeding; and
 - c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

WELLNESS MEDICAL EXPENSE BENEFIT

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1. Routine physical examinations: per Plan term which includes, one routine physical examination, laboratory tests, x-rays and any other medical expense related to the examination.
2. Preventive medical attention: includes, annual Screening Mammogram for women; an annual cervical screening for women; a gynecological exam for women; Immunizations; Contraceptive Devices; Colorectal screening for adults over 50, an annual standard prostate diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

- a) Schizophrenia;
- b) Schizoaffective disorder;
- c) bipolar affective disorder;
- d) major depressive disorder;
- e) specific obsessive-compulsive disorder;

- f) delusional disorders;
- g) obsessive compulsive disorders;
- h) binge eating, anorexia and bulimia; and
- i) panic disorder.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT ALCOHOL and DRUG SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

- a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
- b) managing withdrawal symptoms; and
- c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to sustaining an Injury to natural teeth.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means** charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist, up to up to the maximum amount shown in the Schedule of Benefits per day for the Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment which includes braces and appliances means medical equipment that:

- 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
- 2) can withstand long-term repeated use without replacement;
- 3) is not useful in the absence of an Injury or Sickness; and
- 4) can be used in the home without medical supervision.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

- 1) **Emergency Medical Evacuation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be

paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.

- 2) **Medical Repatriation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your primary place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:
 - a) one-way Economy Transportation;
 - b) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing [and considered necessary by the authorized travel assistance company; or
 - c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.
- 3) **Return of Remains:** In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, co-payment, and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

- 1) Under Federal law may only be dispensed by written prescription; and
- 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

- 1) On or after the Plan Participant's Effective Date; and
- 2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

EXCLUSIONS

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

- 1) War or any act of war, declared or undeclared;
- 2) Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;

- 3) Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 4) Voluntary, active participation in a riot or insurrection;
- 5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;
- 6) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 7) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
- 8) Charges which are in excess of Usual, Reasonable and Customary charges;
- 9) Charges that are not Medically Necessary;
- 10) Charges provided at no cost to the Plan Participant;
- 11) Expenses incurred for treatment while in Your Home Country;
- 12) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 13) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
- 14) Duplicate services actually provided by both a certified nurse midwife and Physician;
- 15) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
- 16) Drug, treatment or procedure that either promotes conception, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 17) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 18) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;
- 19) Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
- 20) Weak, strained or flat feet, corns, calluses, or toenails;
- 21) Private-duty nursing services;
- 22) Expenses payable under any prior policy which was in force for the person making the claim;
- 23) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 24) Pre-existing conditions; however a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization;
- 25) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; motorcycle riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; solo diving; snorkeling; snow skiing; spelunking; parasailing; white water rafting; surfing and snow boarding.

- 26) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 27) Rest cures or custodial care;
- 28) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);
- 29) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
- a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
 - e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
- Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
- 30) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
- 31) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Plan Participant's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30-day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be

deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90-day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:

All claims for benefits under the Policy must be submitted to Us no more than 90 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to His/Her beneficiary as described in the Designation and Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to His beneficiary or to His estate. All other benefits, unless specifically stated otherwise, will be paid to a Plan Participant.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

- 1) Beneficiaries designated in writing by the Plan Participant for the Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Plan Participant's lawful spouse, if not legally separated or divorced, Domestic Partner or Civil Union Partner;
 - b) a Plan Participant's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Plan Participant has or had legal guardianship (proof will be required); or
 - c) a Plan Participant's parents, whether natural, step or adoptive; or
 - d) a Plan Participant's Sisters or Brothers, otherwise.
- 4) The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Plan Participant's estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error or
- 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

- (1) Received in a covered Accident; and
- (2) Which are covered under:
 - (a) workers' compensation or similar statutory remedies available under law; or
 - b) Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

“Recovery” means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

LEGAL ACTIONS:

No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

COMPLAINTS

In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at [\[Administrator/Producer contact information.\]](#)

Data Protection

Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the application of the Policyholder, a copy of which is attached, endorsements, riders, and the application or participation agreement with the Participating Organization and attached papers constitute the entire contract between the parties. If an application of a Plan Participant is required, the application of any Plan Participant, at Our option, may also be made a part of this contract.

All statements made by the Policyholder, Participating Organization, or by a Plan Participant are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Plan Participant's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Plan Participant's insurance under the Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under the Policy. Examination may occur at any reasonable time up to the later of:

- (1) The two year period after the expiration of the Policyholder's coverage; or
- (2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

- (1) The names of all Plan Participants on the Effective Date of the Policy;
- (2) The names of all persons who are Plan Participant after the Effective Date of the Policy;

- (3) The names of those persons whose insurance has terminated; and
- (4) Additional information required as agreed to by Us and the Policyholder.

EVIDENCE OF COVERAGE:

A Evidence of Coverage of insurance will be delivered to the Participating Organization for delivery to each Plan Participant. Each Evidence of Coverage will list the benefits, conditions and limits of the Evidence of Coverage. It will state to whom the benefits will be paid.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

OTHER COVERAGE WITH US:

At any one time each Plan Participant may have only one Evidence of Coverage issued by Us having coverage similar to that described in the Policy. If we find He has more than one such Evidence of Coverage, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Evidence of Coverages for concurrent periods of coverage.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Plan Participants under the Policy.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

Addendum #1 - Attachment #6

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

36%

of members enrolled at your school have a claim compared to

57%

of members enrolled on Wellfleet's book

LOUISIANA TECH UNIV

Member Count by Age per Year

	2023	2024
<18	17	19
18-21	153	377
22-26	130	140
27-35	115	134
>35	14	23
Grand Total	429	691

LOUISIANA TECH UNIV

	2023	2024
<18	4%	3%
18-21	36%	54%
22-26	30%	20%
27-35	27%	19%
>35	3%	3%

WELLFLEET BOOK

	2022	2023	2024	2025
<18	3%	4%	4%	3%
18-21	47%	46%	46%	48%
22-26	32%	30%	30%	29%
27-35	14%	17%	16%	17%
>35	3%	4%	4%	3%

All

Unknown0%

Domestic0%

International100%

Wellfleet Book

Unknown0%

International42%

Domestic58%

Based on policy respective start dates, paid through 4/30/2026

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Addendum #1 - Attachment #7

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance



Cigna StudyWell®

Summary of Benefits for:
Louisiana Tech University
Policy Number: 10676A

Global Health Benefits

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Offered by Cigna Health and Life Insurance Company or its affiliates.



Insured and/or administered by:
Cigna Global Insurance Company Limited

Louisiana Tech University
Benefits at a Glance
Global Plan for all covered Members
Policy # 10676A
Plan Start Date September 1, 2025

This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

Cigna Healthcare, Global Health Benefits Customer Service		
Toll Free Telephone Number:	1.800.441.2668	
Direct Telephone:	1.302.797.3100 (collect calls accepted)	
Toll Free Fax Number:	1.800.243.6998	
Direct Fax Number:	001.302.797.3150	
Secure Website:	www.CignaEnvoy.com Registration is required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Healthcare P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Healthcare 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Annual Maximum	\$250,000		
Policy Year Deductible · Per Individual	\$0	\$200	\$400
· Per Family	\$0	\$400	\$800
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	75%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual	\$0	\$5,000	\$7,500
· Per Family	\$0	\$10,000	\$20,000



Global Medical Plan

Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit · Surgery Performed In the Physician's Office	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Student Health Center (if applicable)	Not Covered	100% not subject to deductible	100% not subject to deductible
Preventive Care · Routine Preventive Care · Policy Year Maximum: · Immunizations	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
Travel Immunizations (Immunizations as required for travel)	Not Covered	Not Covered	Not Covered
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	Not Covered	Not Covered	Not Covered
Inpatient Hospital · Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate) · Inpatient Hospital Physician Visits/Consultations · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% 100% 100%	\$200 copay, then 100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Services · Outpatient Facility Services · Outpatient Professional Services	100% 100%	100% after deductible 100% after deductible	75% after deductible 75% after deductible
Emergency Room	100%	\$350 per visit copay, then 100% not subject to deductible	\$350 per visit copay, then 100% not subject to deductible
Urgent Care Services	100%	\$50 copay, then 100% not subject to deductible	75% after deductible
Ambulance	100%	100% after deductible	75% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Laboratory Services · Physician Office Visit · Outpatient Facility · Laboratory Services at an Independent Lab facility	100% 100% 100%	100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Radiology Services · Physician Office Visit · Outpatient Facility	100% 100%	100% not subject to deductible 100% after deductible	75% after deductible 75% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) · Physician Office Visit · Inpatient Facility · Outpatient Facility	100% 100% 100%	\$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Therapy Services · Physician Office Visit · Outpatient Hospital Facility	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Policy Year Maximum:	20 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational, Cognitive, and Physical Therapy / Physiotherapy.			



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Chiropractic Care Policy Year Maximum:	Not Covered	Not Covered	Not Covered
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	100% after deductible	75% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· Delivery – Facility			
· Inpatient Hospital	100%	\$200 copay, then 100% not subject to deductible	75% after deductible
· Birthing Center	100%	\$200 copay, then 100% not subject to deductible	75% after deductible



Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Infertility, Fertility and Conception Services - Physician Office Visit and Counseling - Lab and Radiology Tests - Inpatient Facility - Outpatient Facility	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered
Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Device / Aids	Not Covered	Not Covered	Not Covered
Dental Care Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth - Physician Office Visit - Inpatient Facility - Outpatient Facility Policy Year Maximum	100% 100% 100%	\$40 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible 100% after deductible \$1,000	75% after deductible 75% after deductible 75% after deductible
Mental Health - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder) - Inpatient Facility Maximum: (combined with Substance Use Disorder)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible
Substance Use Disorder - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health) - Inpatient Facility Maximum: (combined with Mental Health)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay, then 100% not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible

Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	No Charge, not subject to plan deductible	
Purchased Inside the United States Only		
Benefit Highlights	Network Pharmacy (U.S. In-Network)	Non-Network Pharmacy (U.S. Out-of-Network)
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$20 copay	You pay 25% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$50 copay	You pay 25% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$75 copay	You pay 25% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$60 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$150 copay	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$225 copay	In-Network coverage only



Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Performance 3-Tier
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
Utilization Management	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Legacy 3-Tier"	

Global Evacuation Plan	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses for approved services.
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of Other
Return of Dependent Children	One-way Airfare at Economy Rates to return dependent children to country of residence
Repatriation of Mortal Remains	100% coverage



Global Telehealth

Teladoc Health International	Global telehealth gives you no cost 24/7 access to licensed doctors for non-emergency health issues. Common outreaches include fever, rash, pain, non-emergency pediatric care, and more. Referrals to specialists and prescriptions available when medically necessary and locally permitted. Telephone or video consultations can be arranged through Cigna Envoy (cignaenvoy.com).

Global Accidental Death & Dismemberment

Member Benefit	A flat benefit amount of \$10,000
Reduction of Benefits	To 65% at age 65 and 50% at age 70; Terminate at Retirement
Scope of Coverage	24 Hour Coverage

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We're here for you, anytime you need us, 24/7/365 customer service

Cigna HealthcareSM, Global Health Benefits delivers world-class customer service and support to our clients and their globally mobile employees – at every stage of a global assignment. It does not matter where our clients or customers are working or what time zone – our global service center is open 24 hours a day, seven days a week.

You can also contact Cigna Healthcare through the secure mailbox in [Cigna Envoy](#)[®].*

Contact us options

Toll-free telephone number	+1.800.441.2668
Toll-free TDD telephone number (for the hearing impaired)	+1.800.558.3604
Direct phone (collect calls accepted)	+1.302.746.3059
Toll-free facsimile number	+1.800.243.6998
Direct facsimile number (inside the U.S.)	+1.302.797.3150
Website	CignaEnvoy.com

Global Health Benefits



*Web-based tools, such as Cigna Envoy[®] are available for informational purposes only. These tools are not intended to be a substitute for medical care provided by a physician. The listing of a health care professional or facility in the mobile directories available through the Cigna Envoy mobile app does not guarantee that the services rendered by that professional or facility are covered under your benefits plan. Refer to your plan documents, or call the number listed on your ID card, for information about the services covered under your plan benefits. References to non-partnered organizations or companies, and/or their products, processes or services, do not necessarily constitute an endorsement or warranty thereof.

Product availability may vary by location and plan type and is subject to change. Products may not be available in all jurisdictions and are excluded where prohibited by law. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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BENEFITS AT A GLANCE

INTERNATIONAL STUDENT ACCIDENT AND SICKNESS PLAN | PLAN YEAR 2024/2025



DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

LOUISIANA TECH UNIVERSITY

Ruston, Louisiana

Policy Number: CC008771

Effective: 09/04/2024 – 09/03/2025

Group Number: ST2249LM

UNDERWRITTEN BY:

Crum & Forster, SPC

ADMINISTERED BY:

Wellfleet Group, LLC

If any discrepancy exists between this brochure and the Policy, the Policy will govern.

Welcome International Students...

We are pleased to provide you with this summary of the 2024 – 2025 International Student Accident and Sickness Plan (“Plan”), “Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information.

Important Contact Information & Resources



Contact Us

PLAN ADMINISTERED BY

**Enrollment, Eligibility, & Waivers
Servicing Agent**

Compass Student Insurance
116 Village Blvd Suite 306
Princeton, NJ 08540
781-356-1999

Benefits, Claim Status, & Administration

Wellfleet Group, LLC
PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
Monday–Thursday, 8:30 a.m. to 7:00 p.m.
Eastern Time
Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time



Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com.

Your plan includes Wellfleet Rx – offering over 40 generics at a \$0 co-payment. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here <http://www.wellfleetrx.com/students/formularies/> for more information.

Member Pharmacy Help

(877) 640-7940



PPO Network



Cigna
www.mycigna.com

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General Information

Am I Eligible

Class 1: International Students

All International Students (Plan Participants) of the Louisiana Tech University will be automatically enrolled in this International Student Accident and Sickness Plan. Eligible International Students do not have the option to waive coverage.

J-1 Scholars and OPT participants are also eligible, but they are not automatically enrolled. Please see below for instructions on how to enroll.

Class 2: Dependents

International Students, J-1 Scholars and OPT participants who are enrolled in this International Student Accident and Sickness Plan may also enroll their eligible Dependents.

U.S. citizens and residents are not eligible for coverage.

How Do I Enroll If I Am a J-1 Scholar or On OPT, or If I Need To Enroll My Dependents?

- i. To enroll as a J-1 Scholar or a student on OPT (including dependents of a J-1 Scholar or OPT), click the link below.
 - Go to [J-1 Scholar and OPT Enrollment](#)
 - Click the “Enroll” tab and proceed as directed to enroll in and purchase the International Student Accident and Sickness Plan.
- ii. If you are an International Student enrolled in the plan through Louisiana Tech, you will need to enroll your dependents through MyInsurance.
 - Go to [Dependents of International Students](#)

Refer to the dates in the Effective Date & Costs section for the deadline dates to purchase dependent coverage.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date
Annual	09/04/2024	09/03/2025
Fall	09/04/2024	11/27/2024
Winter	11/28/2024	03/11/2025
Spring	03/12/2025	06/02/2025
Summer	06/03/2025	09/03/2025

Plan Costs for International Students and their eligible Dependents

	Annual	Fall	Winter	Spring	Summer
Student	\$1,218.20	\$304.55	\$304.55	\$304.55	\$304.55
Spouse	\$2,676.92	\$669.23	\$669.23	\$669.23	\$669.23
Child(ren)	\$2,676.92	\$669.23	\$669.23	\$669.23	\$669.23

The plan costs for Dependents are in addition to the plan costs for student.

Plan Benefits

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-payment amount.
- Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

BENEFIT	IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
Policy Maximum for all Injury and Sickness Medical Expenses	\$250,000	
Policy Term Deductible* Per Individual	\$200	
Deductible at Student Health Center: *Deductible waived for covered services rendered at Student Health Center	\$0	
Student Health Center Coverage paid at 100%.		
Initial Treatment Period	90 Days from the date of Injury or Sickness	

Out-of-Pocket Maximum Per Policy Term: Individual	\$5,000	
Coinsurance	100% of the Preferred Allowance (PA)	80% of Usual, Reasonable & Customary (URC) Charges

Schedule of Benefits

UNLESS OTHERWISE SPECIFIED BELOW, THE POLICY TERM DEDUCTIBLE WILL ALWAYS APPLY

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
Hospital Room & Board Benefit	100% of the PA, subject to a \$50 co-payment per admission	80% of URC
Intensive Care/Cardiac Care Unit Benefit	100% of the PA	80% of URC
Hospital Miscellaneous Expense Benefit	100% of the PA	80% of URC
Surgeon (In or Outpatient) Benefits	100% of the PA	80% of URC
Assistant Surgeon Benefit	100% of the PA	80% of URC
Pre-Admission Testing Benefit	100% of the PA	80% of URC
Anesthesia Benefit	100% of the PA	80% of URC
Day Surgery Miscellaneous Benefit	100% of the PA	80% of URC
Diagnostic X-Ray and Lab Benefit	100% of the PA	80% of URC
Ambulance Benefit	100% of the PA	80% of URC
Physician Visit Benefit (Inpatient)	100% of the PA	80% of URC
Physician Visit Benefit (Outpatient)	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Consultant Physician Benefit	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Radiation/Chemotherapy Benefit	100% of the PA	80% of URC
Emergency Room Benefit	100% of the PA, subject to a \$150 co-payment per visit (co-payment waived if admitted)	80% of URC
Extension of Accident and Sickness Medical Benefits (If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 30 days, or the maximum benefit has been paid, whichever occurs first.)	100% of the PA	80% of URC
Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness	Covered as any other Sickness
Wellness Medical Benefit (Up to \$250 per Policy Term)	100% of the PA	80% of URC

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense	100% of the PA	80% of URC
Out-Patient Expense	100% of the PA, subject to a \$25 co-payment per visit for Physician Office Visits	80% of URC
Emergency Dental Expense Benefit	100% of the PA	80% of URC
Physiotherapy Expense Benefit – Inpatient	100% of the PA	80% of URC
Physiotherapy Expense Benefit – Outpatient	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Durable Medical Equipment Expense Benefit	100% of the PA	80% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense, up to \$100,000	
Emergency Medical Repatriation Expense Benefit	Student: 100% of actual expense, up to \$25,000 Spouse & Child: 100% of actual expense, up to \$50,000	
PRESCRIPTION DRUG EXPENSE BENEFIT	WELLFLEET RX/ESI NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
Co-payment Generic:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Co-payment Brand Name Preferred:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Co-payment Brand Name Non-Preferred:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Contraceptive Drugs	Covered per Coinsurance above (For FDA-approved preventive contraceptives: \$0 per prescription based on 30-day supply per prescription, Deductible Waived)	Not Covered
ACCIDENTAL DEATH AND DISMEMBERMENT		
Class 1 – Principal Sum		\$10,000
Class 2 – Principal Sum		\$5,000 Spouse/\$1,000 Child
Loss must occur within 365 days of the date of a covered Accident.		
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.		

THIS IS A LIMITED BENEFIT POLICY. The insurance described in this document provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act. Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this brochure. This plan contains both insurance and non-insurance benefits. Complete provisions pertaining to the insurance portion of the plan are contained in the policy. In the event of any conflict between this brochure and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of your plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to your school. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. This insurance is not subject to, and will not be administered as

a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA compliant insurance coverage. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster SPC.

Exclusions and Limitations

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

- 1) War or any act of war, declared or undeclared;
- 2) Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
- 3) Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 4) Voluntary, active participation in a riot or insurrection;
- 5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;
- 6) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 7) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
- 8) Charges which are in excess of Usual, Reasonable and Customary charges;
- 9) Charges that are not Medically Necessary;
- 10) Charges provided at no cost to the Plan Participant;
- 11) Expenses incurred for treatment while in Your Home Country;
- 12) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 13) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
- 14) Duplicate services actually provided by both a certified nurse-midwife and Physician;
- 15) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
- 16) Drug, treatment or procedure that either promotes conception, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 17) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 18) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;
- 19) Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
- 20) Weak, strained or flat feet, corns, calluses, or toenails;
- 21) Private-duty nursing services;
- 22) Expenses payable under any prior policy which was in force for the person making the claim;

- 23) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 24) Pre-existing conditions; however, a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization;
- 25) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; motorcycle riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; solo diving; snorkeling; snow skiing; spelunking; parasailing; white water rafting; surfing; and snow boarding;
- 26) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 27) Rest cures or custodial care;
- 28) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);
- 29) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
 - e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f) An ultra light, hang-gliding, parachuting or bungi-cord jumping;

Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
- 30) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
- 31) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.

Notice: For further information on this Plan, visit: <https://www.studentinsurance.com/Client/2249>

Please keep this summary as a brief description of the important features of the plan. It is not a contract of insurance. This plan includes both insurance and non-insurance benefits. The terms and conditions of coverage are set forth in the Plan issued for Louisiana Tech University. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. The Policy contains a complete description of all of the terms, conditions, and exclusions of the insurance plan as underwritten by Crum & Forster, SPC. The Policy will prevail in the event of any discrepancy between this Brochure and the Policy.

Note: 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 the policy meets any obligations you may have under PPACA.

Privacy Statement: We know that your privacy is important to you, and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us 877-657-5030 or by visiting us at <https://www.wellfleetstudent.com>.

Complaints: In the event you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at:

Wellfleet Group, LLC
Attention: Appeals Unit
PO Box 15369
Springfield, MA 01115-5369

Data Protection: Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure your information is held securely. Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above. Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

By purchasing this insurance provided by Crum & Forster SPC, under the jurisdiction of the Cayman Islands, you become a member of the Fairmont Specialty Trust.

VALUE ADDED SERVICES

The following are not affiliated with the Insurance Company and the services are not part of the Plan Underwritten by the Insurance Company.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Travel Guard provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Travel Guard at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada: Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
 - a) Request an international operator.
 - b) Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline program provides:

- Phone-based, reliable medical information in response to medical concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- self-care at home
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone medical inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer medical plan benefit questions. Medical benefit questions should be referred to the Plan Administrator. The 24 Hour Nurseline toll free number will be on the ID card.

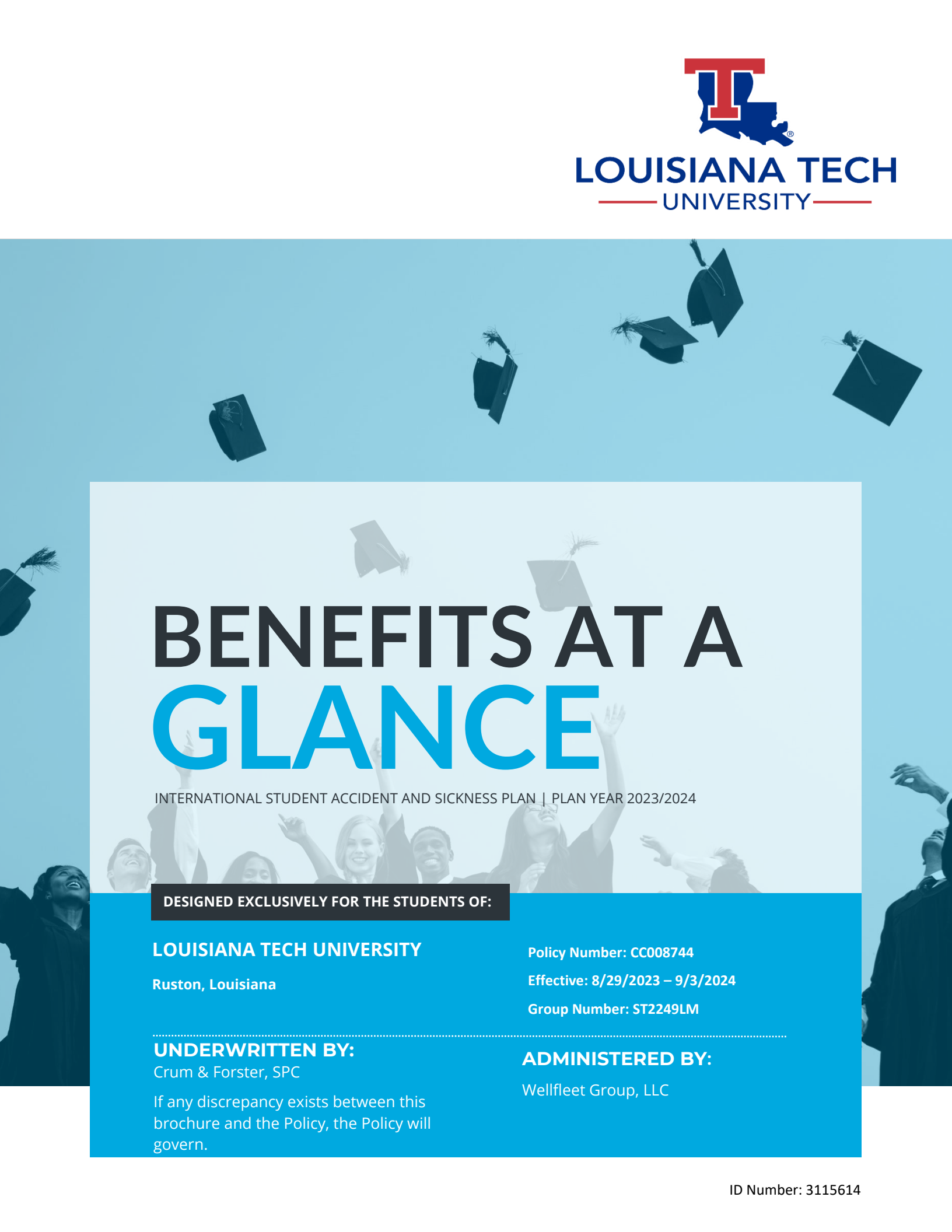
(800) 634-7629



24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral health clinicians 24/7/365 via telephone (888) 857-5462.

Connect to a registered nurse within seconds, helping students manage their health on their terms through easy access.



BENEFITS AT A GLANCE

INTERNATIONAL STUDENT ACCIDENT AND SICKNESS PLAN | PLAN YEAR 2023/2024

DESIGNED EXCLUSIVELY FOR THE STUDENTS OF:

LOUISIANA TECH UNIVERSITY

Ruston, Louisiana

Policy Number: CC008744

Effective: 8/29/2023 – 9/3/2024

Group Number: ST2249LM

UNDERWRITTEN BY:

Crum & Forster, SPC

ADMINISTERED BY:

Wellfleet Group, LLC

If any discrepancy exists between this brochure and the Policy, the Policy will govern.

Welcome International Students...

We are pleased to provide you with this summary of the 2023 – 2024 International Student Accident and Sickness Plan (“Plan”), “Benefits at a Glance” includes effective dates and costs of coverage, as well as other helpful information.

Important Contact Information & Resources



Contact Us

PLAN ADMINISTERED BY

**Enrollment, Eligibility, & Waivers
Servicing Agent**

Compass Student Insurance

116 Village Blvd Suite 306
Princeton, NJ 08540
781-356-1999

Benefits, Claim Status, & Administration

Wellfleet Group, LLC

PO Box 15369
Springfield, Massachusetts 01115-5369
(877) 657-5030, TTY 711
www.wellfleetstudent.com
Monday–Thursday, 8:30 a.m. to 7:00 p.m.
Eastern Time

Friday, 9:00 a.m. to 5:00 p.m.
Eastern Time



Pharmacy Benefits Manager

For information about the Wellfleet Rx/ESI Prescription Drug Program, please visit www.wellfleetstudent.com.

Your plan includes Wellfleet Rx – offering over 40 generics at a \$0 co-payment. Please ask your health care provider to review our formulary to see if these medications are right for you. Click here <http://wellfleetrx.com/students/formularies/> for more information.

Member Pharmacy Help

(877) 640-7940



PPO Network



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J-1 Scholars and OPT participants are also eligible, but they are not automatically enrolled. Please see below for instructions on how to enroll.

Class 2: Dependents

International Students, J-1 Scholars and OPT participants who are enrolled in this International Student Accident and Sickness Plan may also enroll their eligible Dependents.

U.S. citizens and residents are not eligible for coverage.

How Do I Enroll If I Am a J-1 Scholar or On OPT, or If I Need To Enroll My Dependents?

- i. To enroll as a J-1 Scholar or a student on OPT (including dependents of a J-1 Scholar or OPT), click the link below.
 - Go to [J-1 Scholar and OPT Enrollment](#)
 - Click the “Enroll” tab and proceed as directed to enroll in and purchase the International Student Accident and Sickness Plan.
- ii. If you are an International Student enrolled in the plan through Louisiana Tech, you will need to enroll your dependents through MyInsurance.
 - Go to [Dependents of International Students](#)

Refer to the dates in the Effective Date & Costs section for the deadline dates to purchase dependent coverage.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date
Annual	08/29/2023	09/03/2024
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Winter	11/28/2023	03/11/2024
Spring	03/12/2024	06/02/2024
Summer	06/03/2024	09/03/2024

Plan Costs for International Students and their eligible Dependents

	Annual	Fall	Winter	Spring	Summer
Student	\$1,218.20	\$304.55	\$304.55	\$304.55	\$304.55
Spouse	\$2,676.92	\$669.23	\$669.23	\$669.23	\$669.23
Child(ren)	\$2,676.92	\$669.23	\$669.23	\$669.23	\$669.23

The plan costs for Dependents are in addition to the plan costs for student.

Plan Benefits

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or Co-payment amount.
- Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

BENEFIT	IN-NETWORK PROVIDER	OUT OF NETWORK PROVIDER
Policy Maximum for all Injury and Sickness Medical Expenses	\$250,000	
Policy Term Deductible* Per Individual *Deductible waived for covered services rendered at Student Health Center	\$200	
Initial Treatment Period	90 Days from the date of Injury or Sickness	
Out-of-Pocket Maximum Per Policy Term: Individual	\$5,000	
Coinsurance	100% of the Preferred Allowance (PA)	80% of Usual, Reasonable & Customary (URC) Charges

Schedule of Benefits

UNLESS OTHERWISE SPECIFIED BELOW, THE POLICY TERM DEDUCTIBLE WILL ALWAYS APPLY

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
Hospital Room & Board Benefit	100% of the PA, subject to a \$50 co-payment per Confinement	80% of URC
Intensive Care/Cardiac Care Unit Benefit	100% of the PA	80% of URC
Hospital Miscellaneous Expense Benefit	100% of the PA	80% of URC
Surgeon (In or Outpatient) Benefits	100% of the PA	80% of URC
Assistant Surgeon Benefit	100% of the PA	80% of URC
Pre-Admission Testing Benefit	100% of the PA	80% of URC
Anesthesia Benefit	100% of the PA	80% of URC
Day Surgery Miscellaneous Benefit	100% of the PA	80% of URC
Diagnostic X-Ray and Lab Benefit	100% of the PA	80% of URC
Ambulance Benefit	100% of the PA	80% of UCR
Physician Visit Benefit (Inpatient)	100% of the PA	80% of URC
Physician Visit Benefit (Outpatient)	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Consultant Physician Benefit	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Urgent Care Center Visit Benefit	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Student Health Center Expense Benefit	100% of billed charges (deductible waived)	
Radiation/Chemotherapy Benefit	100% of the PA	80% of URC
Emergency Room Benefit	100% of the PA, subject to a \$150 co-payment per visit (co-payment waived if admitted)	80% of URC
Wellness Medical Benefit (Up to a maximum of \$250 per Policy Term)	100% of the PA	80% of URC
Extension of Accident and Sickness Medical Benefits (If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 30 days, or the maximum benefit has been paid, whichever occurs first.)	100% of the PA	80% of URC
Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness	Covered as any other Sickness
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense	100% of the PA	80% of URC
Out-Patient Expense	100% of the PA, subject to a \$25 co-payment per visit for Physician Office Visits	80% of URC

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
Emergency Dental Expense Benefit	100% of the PA	80% of URC
Physiotherapy Expense Benefit – Inpatient	100% of the PA	80% of URC
Physiotherapy Expense Benefit – Outpatient	100% of the PA, subject to a \$25 co-payment per visit	80% of URC
Durable Medical Equipment Expense Benefit	100% of the PA	80% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense, up to \$100,000	
Emergency Medical Repatriation Expense Benefit	Student: 100% of actual expense, up to \$25,000 Spouse & Child: 100% of actual expense, up to \$50,000	
PRESCRIPTION DRUG EXPENSE BENEFIT	WELLFLEET RX/ESI NETWORK PROVIDER BENEFIT	OUT OF NETWORK PROVIDER BENEFIT
Co-payment Generic:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Co-payment Brand Name Preferred:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Co-payment Brand Name Non-Preferred:	75% of the PA based on a 30-day supply per prescription.	Not Covered
Contraceptive Drugs	Covered per Coinsurance above (For FDA-approved preventive contraceptives: \$0 per prescription based on 30-day supply per prescription, Deductible Waived)	Not Covered
ACCIDENTAL DEATH AND DISMEMBERMENT		
Class 1 – Principal Sum		\$10,000
Class 2 – Principal Sum		\$5,000 Spouse/\$1,000 Child
Loss must occur within 365 days of the date of a covered Accident.		
Only one benefit will be payable under this provision, that providing the largest benefit, when more than one (1) loss occurs as the result of any one (1) Accident. This benefit is payable in addition to any other benefits payable under this Certificate.		

THIS IS A LIMITED BENEFIT POLICY. The insurance described in this document provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act. Benefits are provided for eligible Insured Persons. Terms and conditions are briefly outlined in this brochure. This plan contains both insurance and non-insurance benefits. Complete provisions pertaining to the insurance portion of the plan are contained in the policy. In the event of any conflict between this brochure and the policy, the policy will govern. The policy is a short-term limited duration policy renewable only at the option of the insurer. This is a brief description of the important features of your plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Plan issued to your school. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA compliant insurance coverage. This policy is not subject to guaranteed issuance or renewal. PPO Networks are not provided by Crum & Forster SPC.

Exclusions and Limitations

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

- 1) War or any act of war, declared or undeclared;
- 2) Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
- 3) Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 4) Voluntary, active participation in a riot or insurrection;
- 5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;
- 6) For any Covered Losses resulting from the Plan Participant's intoxication;
- 7) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 8) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
- 9) Charges which are in excess of Usual, Reasonable and Customary charges;
- 10) Charges that are not Medically Necessary;
- 11) Charges provided at no cost to the Plan Participant;
- 12) Expenses incurred for treatment while in Your Home Country;
- 13) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 14) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
- 15) Duplicate services actually provided by both a certified nurse-midwife and Physician;
- 16) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
- 17) Drug, treatment or procedure that promotes conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency;
- 18) Sterilization or reversal thereof;
- 19) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 20) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;
- 21) Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
- 22) Weak, strained or flat feet, corns, calluses, or toenails;
- 23) Private-duty nursing services;
- 24) Expenses payable under any prior policy which was in force for the person making the claim;
- 25) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;

- 26) Pre-existing conditions; however, a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization;
- 27) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; **solo diving** snorkeling; spelunking; parasailing; white water rafting; surfing; and snow boarding;
- 28) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 29) Rest cures or custodial care;
- 30) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);
- 31) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
 - e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f) An ultra light, hang-gliding, parachuting or bungi-cord jumping;

Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes;
- 32) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly;
- 33) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction;

Notice: For further information on this Plan, visit: <https://www.studentinsurance.com/Client/2249>

Please keep this summary as a brief description of the important features of the plan. It is not a contract of insurance. This plan includes both insurance and non-insurance benefits. The terms and conditions of coverage are set forth in the Plan issued for Louisiana Tech University. For a detailed plan description, exclusions, and limitations please view the plan on file with your school. The Policy contains a complete description of all of the terms, conditions, and exclusions of the insurance plan as underwritten by Crum & Forster, SPC. The Policy will prevail in the event of any discrepancy between this Brochure and the Policy.

Note: 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 the policy meets any obligations you may have under PPACA.

Privacy Statement: We know that your privacy is important to you, and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us 877-657-5030 or by visiting us at <https://www.wellfleetstudent.com>.

Complaints: In the event you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at:

Wellfleet Group, LLC
Attention: Appeals Unit
PO Box 15369
Springfield, MA 01115-5369

Data Protection: Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure your information is held securely. Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above. Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

By purchasing this insurance provided by Crum & Forster SPC, under the jurisdiction of the Cayman Islands, you become a member of the Fairmont Specialty Trust.

VALUE ADDED SERVICES

The following are not affiliated with the Insurance Company and the services are not part of the Plan Underwritten by the Insurance Company.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Travel Guard provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Travel Guard at (877) 657-5030, TTY 711.

If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.

When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

How to Access Services

If you require medical assistance or you need assistance with a non-medical situation, such as lost luggage, lost documents or other travel issues, follow these steps:

- Inside the U.S. and Canada: Dial toll-free **(877) 305-1966**
- Outside the U.S. and Canada:
 - a) Request an international operator.
 - b) Request the operator to place a collect call to the U.S. at **+1 (715) 295-9311**.

Please provide the following information when you call:

- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

24 Hour Nurseline

Students who enroll and maintain medical coverage in this insurance plan have access to the 24 Hour Nurseline. This 24-Hour Nurseline program provides:

- Phone-based, reliable medical information in response to medical concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include:

- self-care at home
- a call to a physician
- or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone medical inquiries.

This program is not a substitute for doctor visits or emergency response systems. The Nurseline does not answer medical plan benefit questions. Medical benefit questions should be referred to the Plan Administrator. The 24 Hour Nurseline toll free number will be on the ID card.

(800) 634-7629



24/7 Behavioral Telehealth and Nurseline Access

CareConnect is an integrated behavioral health program offering students easy access to licensed behavioral health clinicians 24/7/365 via telephone (888) 857-5462.

Connect to a registered nurse within seconds, helping students manage their health on their terms through easy access.

Addendum #1 - Attachment #8

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	High Dollar Claimant	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	Plan Year All			Utilization Metric All	NetworkStatus All	High Dollar Threshold 50,000	Division All		Age Bracket All

LOUISIANA TECH UNIV
Claimants Exceeding \$50,000 in Paid Claims

Year	Masked ID	Highest Paid Diagnosis	Relationship	Grand Total	Inpatient Amount	Outpatient Amount	RX Amount
2023	000233764194	OTHER PARTIAL INTESTINAL OBSTRUCTION	Member	\$151,594	\$139,653	\$5,339	\$6,602
	000141345413	BIPOLAR DISORD, CRNT EPISODE MIXED, SEVERE, W PSYCH FE..	Member	\$106,797	\$106,797		\$0
	000233753547	UNSPECIFIED OPTIC NEURITIS	Member	\$50,883	\$32,043	\$18,226	\$614
	Total			\$309,275	\$278,493	\$23,566	\$7,216
2024	000237049203	DISPLACED COMMINUTED FRACTURE OF SHAFT OF RIGHT FEM..	Member	\$90,996	\$59,746	\$30,201	\$1,049
	000233759917	PRESCRIPTION DRUGS	Member	\$52,098		\$4,479	\$47,619
	000233760010	SINGLE LIVEBORN INFANT, DELIVERED VAGINALLY	Dependent	\$50,203	\$40,558	\$703	\$8,942
	Total			\$193,297	\$100,304	\$35,382	\$57,611
Grand Total				\$502,571	\$378,797	\$58,948	\$64,827

Based on policy respective start dates, paid through 4/30/2026
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Addendum #1 - Attachment #9

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

36%

of members enrolled at your school have a claim compared to

57%

of members enrolled on Wellfleet's book

LOUISIANA TECH UNIV

Member Count by Age per Year

	2023	2024
<18	17	19
18-21	153	377
22-26	130	140
27-35	115	134
>35	14	23
Grand Total	429	691

LOUISIANA TECH UNIV

	2023	2024
<18	4%	3%
18-21	36%	54%
22-26	30%	20%
27-35	27%	19%
>35	3%	3%

WELLFLEET BOOK

	2022	2023	2024	2025
<18	3%	4%	4%	3%
18-21	47%	46%	46%	48%
22-26	32%	30%	30%	29%
27-35	14%	17%	16%	17%
>35	3%	4%	4%	3%

All

Unknown0%

Domestic0%

International100%

Wellfleet Book

Unknown0%

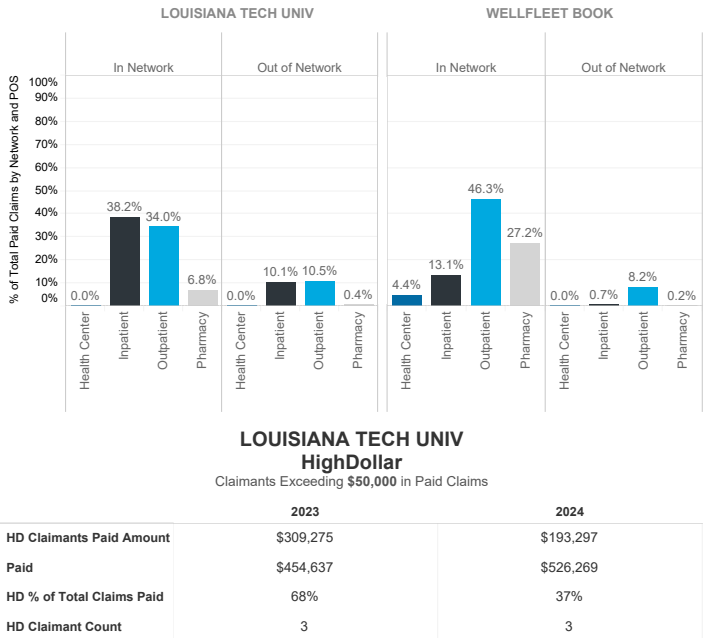
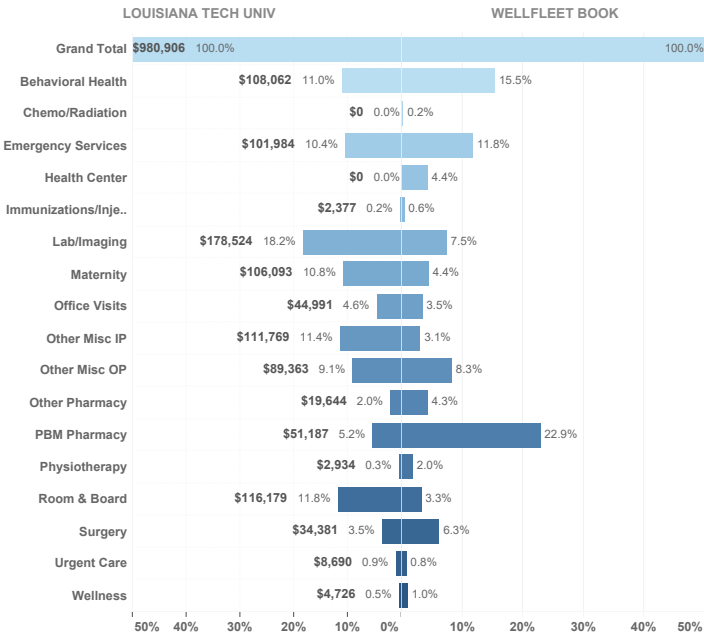
International42%

Domestic58%

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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	All	Plan Year	Report Type Life to Date	All	Utilization Metric	All	NetworkStatus	All	Division

LOUISIANA TECH UNIV

	Paid Claims Amount		Paid Claims Change %		Paid Claims Per Member		Paid Claims Per Member Change %	
	2023	2024	2023	2024	2023	2024	2023	2024
Health Center	\$0	\$0			\$0	\$0		
Behavioral Health	\$107,520	\$542		-99%	\$411	\$1		-100%
Lab/Imaging	\$46,327	\$132,198		185%	\$177	\$356		101%
Surgery	\$5,663	\$28,718		407%	\$22	\$77		257%
Emergency Services	\$39,851	\$62,133		56%	\$153	\$167		10%
All Other Inpatient	\$185,403	\$133,419		-28%	\$710	\$360		-49%
All Other Outpatient	\$57,189	\$111,111		94%	\$219	\$300		37%
Pharmacy	\$12,684	\$58,147		358%	\$49	\$157		223%
Grand Total	\$454,637	\$526,269		16%	\$1,740	\$1,419		-18%

Average Daily Membership

	ADM	% Change
Average Daily Membership 2023:	261.3	
Average Daily Membership 2024:	371.0	42.0%

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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Comparison	Medical Cost Per Member	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	All	Plan Year	Report Type Life to Date	Display Metric Claimants	Utilization Metric All	NetworkStatus All		Division All	Age Bracket All

LOUISIANA TECH UNIV									
		Claimant Count		Paid Claims Amount		Paid Claim by Claimant LTD		% of Plan Payments	
		2023	2024	2023	2024	2023	2024	2023	2024
Health Center	Health Center	0	0	\$0	\$0			0.00%	0.00%
	Category Total	0	0	\$0	\$0			0.00%	0.00%
Inpatient	Behavioral Health	1	0	\$106,688	\$0	\$106,688		23.47%	0.00%
	Lab/Imaging	2	4	\$19,010	\$8,756	\$9,505	\$2,189	4.18%	1.66%
	Maternity	5	2	\$37,526	\$53,348	\$7,505	\$26,674	8.25%	10.14%
	Other Misc IP	5	6	\$73,479	\$38,291	\$14,696	\$6,382	16.16%	7.28%
	Room & Board	2	4	\$74,398	\$41,781	\$37,199	\$10,445	16.36%	7.94%
	Surgery	1	3	\$5,288	\$15,259	\$5,288	\$5,086	1.16%	2.90%
	Category Total	16	19	\$316,389	\$157,433	\$19,774	\$8,286	69.59%	29.92%
Outpatient	Behavioral Health	2	6	\$832	\$542	\$416	\$90	0.18%	0.10%
	Chemo/Radiation	0	0	\$0	\$0			0.00%	0.00%
	Emergency Ser...	14	30	\$39,851	\$62,133	\$2,846	\$2,071	8.77%	11.81%
	Immunizations/I...	7	4	\$2,211	\$166	\$316	\$41	0.49%	0.03%
	Lab/Imaging	70	130	\$27,317	\$123,442	\$390	\$950	6.01%	23.46%
	Maternity	3	3	\$6,117	\$9,103	\$2,039	\$3,034	1.35%	1.73%
	Office Visits	111	197	\$15,050	\$29,941	\$136	\$152	3.31%	5.69%
	Other Misc OP	40	69	\$30,161	\$59,201	\$754	\$858	6.63%	11.25%
	Physiotherapy	2	4	\$270	\$2,665	\$135	\$666	0.06%	0.51%
	Surgery	25	41	\$375	\$13,460	\$15	\$328	0.08%	2.56%
	Urgent Care	14	37	\$1,570	\$7,120	\$112	\$192	0.35%	1.35%
	Wellness	15	38	\$1,811	\$2,915	\$121	\$77	0.40%	0.55%
	Category Total	303	559	\$125,564	\$310,688	\$414	\$556	27.62%	59.04%
Pharmacy	Other Pharmacy	18	31	\$7,553	\$12,091	\$420	\$390	1.66%	2.30%
	PBM Pharmacy	75	138	\$5,131	\$46,056	\$68	\$334	1.13%	8.75%
	Category Total	93	169	\$12,684	\$58,147	\$136	\$344	2.79%	11.05%
Grand Total		406	742	\$454,637	\$526,269	\$1,120	\$709	100.00%	100.00%

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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	High Dollar Claimant	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	Plan Year All			Utilization Metric All	NetworkStatus All	High Dollar Threshold 50,000	Division All		Age Bracket All

LOUISIANA TECH UNIV
Claimants Exceeding \$50,000 in Paid Claims

Year	Masked ID	Highest Paid Diagnosis	Relationship	Grand Total	Inpatient Amount	Outpatient Amount	RX Amount
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	Total			\$193,297	\$100,304	\$35,382	\$57,611
Grand Total				\$502,571	\$378,797	\$58,948	\$64,827

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LOUISIANA TECH UNIV

Plan Year: All

Subset Labels	Provider	Paid	Claimants	Services	Running Total
Top 20 Providers	CLHG RUSTON LLC	\$263,887	251	1,645	\$263,887
	UNIVERSITY HEALTH SHREVEPORT L	\$186,163	6	131	\$450,050
	HENRY MAYO NEWHALL MEM HOSPI..	\$104,981	1	10	\$555,031
	ST FRANCIS MEDICAL CENTER	\$58,738	2	31	\$613,769
	LSU HEALTH SCIENCES CENTER	\$29,096	6	196	\$642,865
	OCHSNER LSU HEALTH SHREVEPOR..	\$21,171	2	49	\$664,036
	THE CARLE FOUNDATION HOSPITAL	\$19,561	2	24	\$683,596
	NORTHERN LA EMERGENCY PHYS L..	\$17,471	26	41	\$701,067
	GREEN CLINIC	\$17,143	35	166	\$718,210
	STANFORD HEALTH CARE	\$14,898	1	16	\$733,108
	WILLIS KNIGHTON MEDICAL CENTER	\$12,835	1	13	\$745,943
	NATERA INC	\$9,838	3	15	\$755,781
	CARLE HEALTH CARE INCORPORAT..	\$8,160	2	7	\$763,941
	ARENA ANESTHESIA LLC	\$5,026	6	13	\$768,967
	WOMANS CLINIC OF MONROE AMC	\$4,867	3	26	\$773,834
	CHRISTUS SANTA ROSA HEALTHCA..	\$4,678	1	19	\$778,512
	HULIN URGENT CARE SERVICES LLC	\$4,511	26	56	\$783,024
	SAN JOSE HEALTHCARE SYSTEM LP	\$3,325	1	7	\$786,349
	RUSTON LINCOLN AMBULANCE	\$3,181	4	10	\$789,529
	COASTAL URGENT CARE LLC	\$3,125	19	26	\$792,654

Student Health Centers and PBMs are excluded from this report

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Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	Plan Year All	Report Type Life to Date	Provider All	Utilization Metric All	NetworkStatus All		All	Division All	Age Bracket

LOUISIANA TECH UNIV

		Paid Claims Amount		% of Total Paid	
		2023	2024	2023	2024
	Unclassified	\$23,767	\$16,875	5.23%	3.21%
	Rx	\$5,131	\$46,056	1.13%	8.75%
A00 - B99	Infectious and parasitic diseases	\$3,136	\$9,700	0.69%	1.84%
C00 - D49	Neoplasms	\$483	\$99	0.11%	0.02%
D50 - D89	Blood and immune diseases	\$346	\$1,997	0.08%	0.38%
E00 - E90	Endocrine, nutritional and metabolic diseases	\$1,882	\$16,282	0.41%	3.09%
F01 - F99	Mental and behavioral disorders	\$107,520	\$2,331	23.65%	0.44%
G00 - G99	Diseases of the nervous system	\$1,013	\$14,889	0.22%	2.83%
H00 - H59	Diseases of the eye and adnexa	\$31,197	\$4,737	6.86%	0.90%
H60 - H95	Diseases of the ear and mastoid process	\$1,332	\$1,207	0.29%	0.23%
I00 - I99	Diseases of the circulatory system	\$4,340	\$6,768	0.95%	1.29%
J00 - J99	Diseases of the respiratory system	\$6,143	\$7,262	1.35%	1.38%
K00 - K99	Diseases of the digestive system	\$134,666	\$13,370	29.62%	2.54%
L00 - L99	Diseases of the skin and subcutaneous tissue	\$1,763	\$13,667	0.39%	2.60%
M00 - M99	Diseases of the musculoskeletal system and ...	\$3,530	\$17,359	0.78%	3.30%
N00 - N99	Diseases of the genitourinary system	\$1,345	\$13,611	0.30%	2.59%
O00 - O9A	Pregnancy, childbirth and the puerperium	\$36,445	\$18,592	8.02%	3.53%
P00 - P96	Certain conditions originating in the perinatal ...	\$198	\$2,236	0.04%	0.42%
Q00 - Q99	Congenital malformations, deformations and ...	\$0	\$0	0.00%	0.00%
R00 - R99	Symptoms, signs and abnormal clinical and l...	\$59,243	\$84,496	13.03%	16.06%
S00 - T98	Injury, poisoning and certain other consequ...	\$4,605	\$122,669	1.01%	23.31%
V00 - Y99	External causes of morbidity	\$0	\$1,091	0.00%	0.21%
Z00 - Z99	Factors influencing health status and contact...	\$26,554	\$110,975	5.84%	21.09%
Grand Total		\$454,637	\$526,269	100.00%	100.00%

Based on policy respective start dates, paid through 4/30/2026
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School Name

LOUISIANA TECH UNIV

Plan Year

All

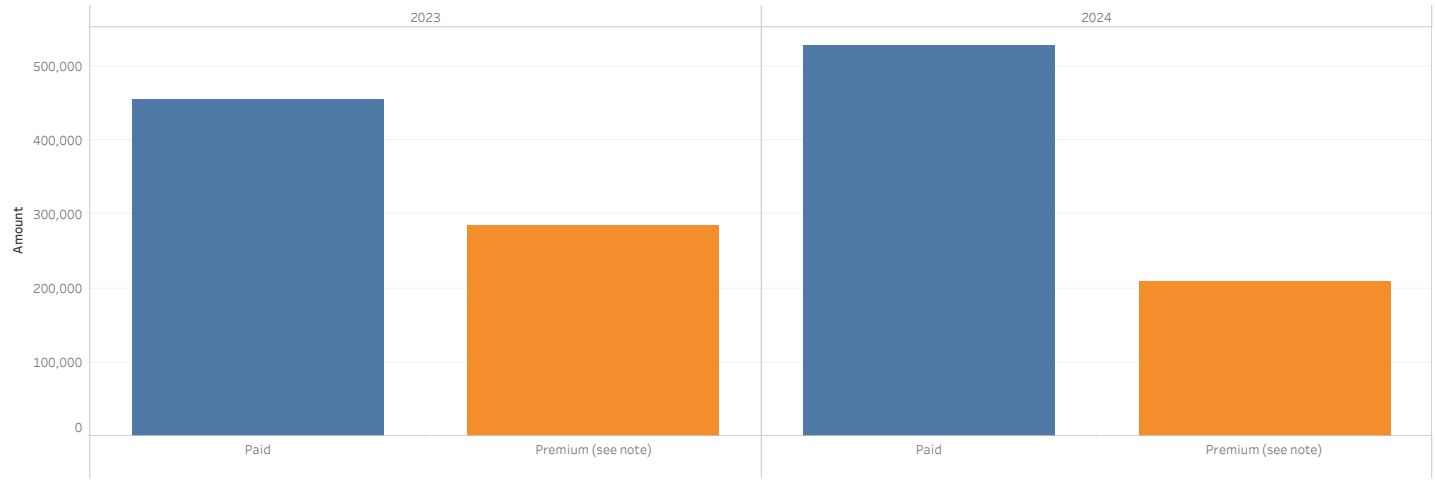
Premium and Loss Ratio

	2023	2024
Premium	\$285,188	\$209,182
Paid	\$454,637	\$526,269
Loss Ratio	159.42%	251.58%

Measure Names

Paid

Premium (see note)



*Please Note : Premium comprises final policy year premium except for the current year where it comprises premium collected to date.

Based on policy respective start dates, paid through 4/30/2026
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8/1/2026 to 4/30/2028	Students and Dependents	Students	Billed Premium	Claimants	# of Claims	Paid Claims	Paid Medical Claims	Paid Rx Claims	In-Network Claims	Loss Ratio	% ER claims	% MN/SA claims	% Student Center
10676A Louisiana Tech University	317	317	\$345,256	164	993	\$227,324	\$217,032	\$10,292	97.1%	65.8%	20.1%	9.4%	31.7%

Expected Mature Loss ratio

81.0%

Claimants over \$20,000

4

Top 5 Diagnostic Class	
10676A Louisiana Tech University	
Supplemental Factors Influencing Health	
Symptoms, Signs, And Ill-Defined Conditions	
Musculoskeletal System & Connective Tissue	
Injury And Poisoning	
Complication Of Pregnancy, Childbirth, And The Puerperium	



UTILIZATION REPORT

Report for Louisiana Tech University



May 2026

Offered by Cigna Health and Life Insurance Company or its affiliates



CONTENTS

Louisiana Tech University

Groups Included:

LOUISIANA TECH UNIVERSITY

Current Period:

Sep 2025 - Mar 2026 Incurred Claims

Sep 2025 - May 2026 Paid Claims

Prior Period:

Sep 2024 - Mar 2025 Incurred Claims

Sep 2024 - May 2025 Paid Claims

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1. Key Metrics
2. Gender and Age Distribution
3. Membership and Spend by Demographic Profile
4. US V Non-US Spend
5. Member Location and Spend by Incurred Country
6. Network Utilization Summary
7. Medical Service Category Distribution
8. Medical Top Diagnostic Categories
- 9 Preventive Care Utilization
10. Pharmacy Key Metrics

All costs are computed in USD (\$)

All utilization metrics are annualized

Metrics are computed using Incurred type basis

Completion factors are not applied to cost or utilization



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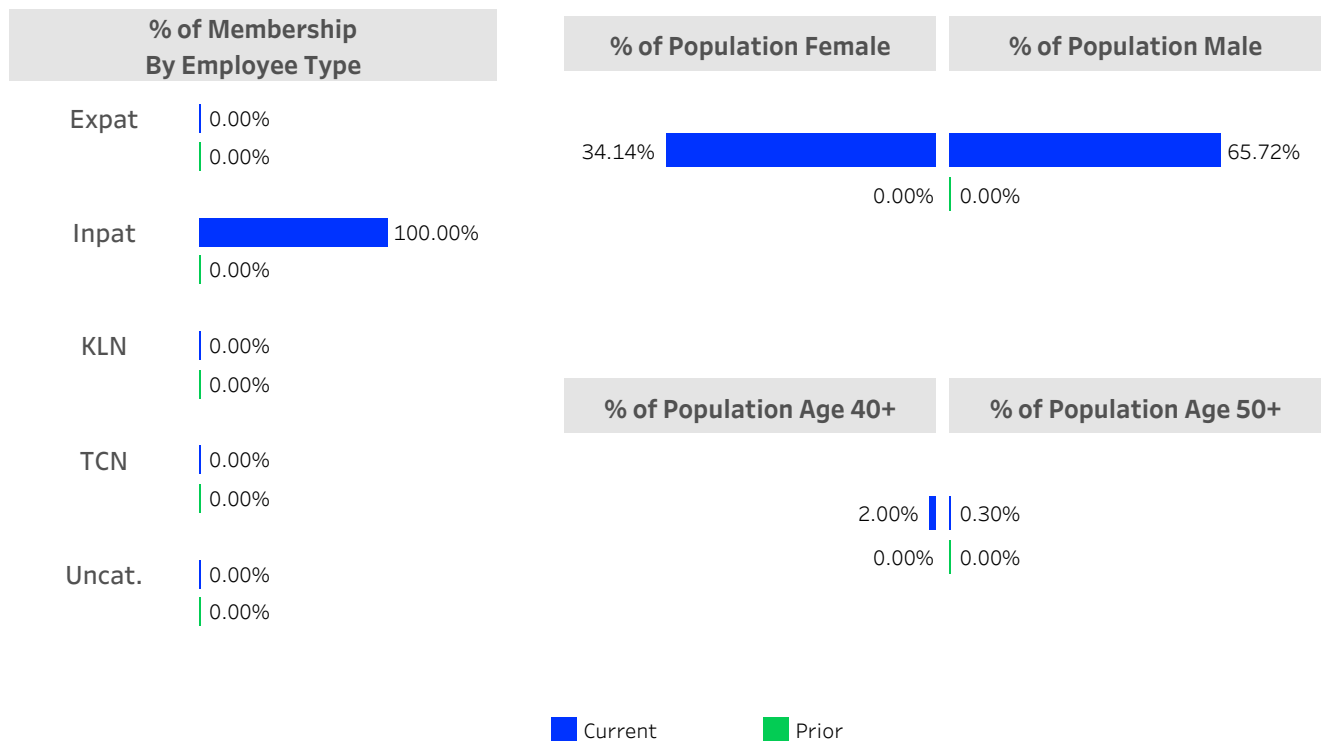


Key Metrics

Sep 2025 - Mar 2026

Louisiana Tech University

Average Number of Employees	Average Number of Members	Average Employee Age	Average Member Age
428 Current ▲ 100.00%	429 Current ▲ 100.00%	24.98 Current ▲ 7.06%	24.92 Current ▲ 7.01%
Prior 0	Prior 0	Prior 23.33	Prior 23.29



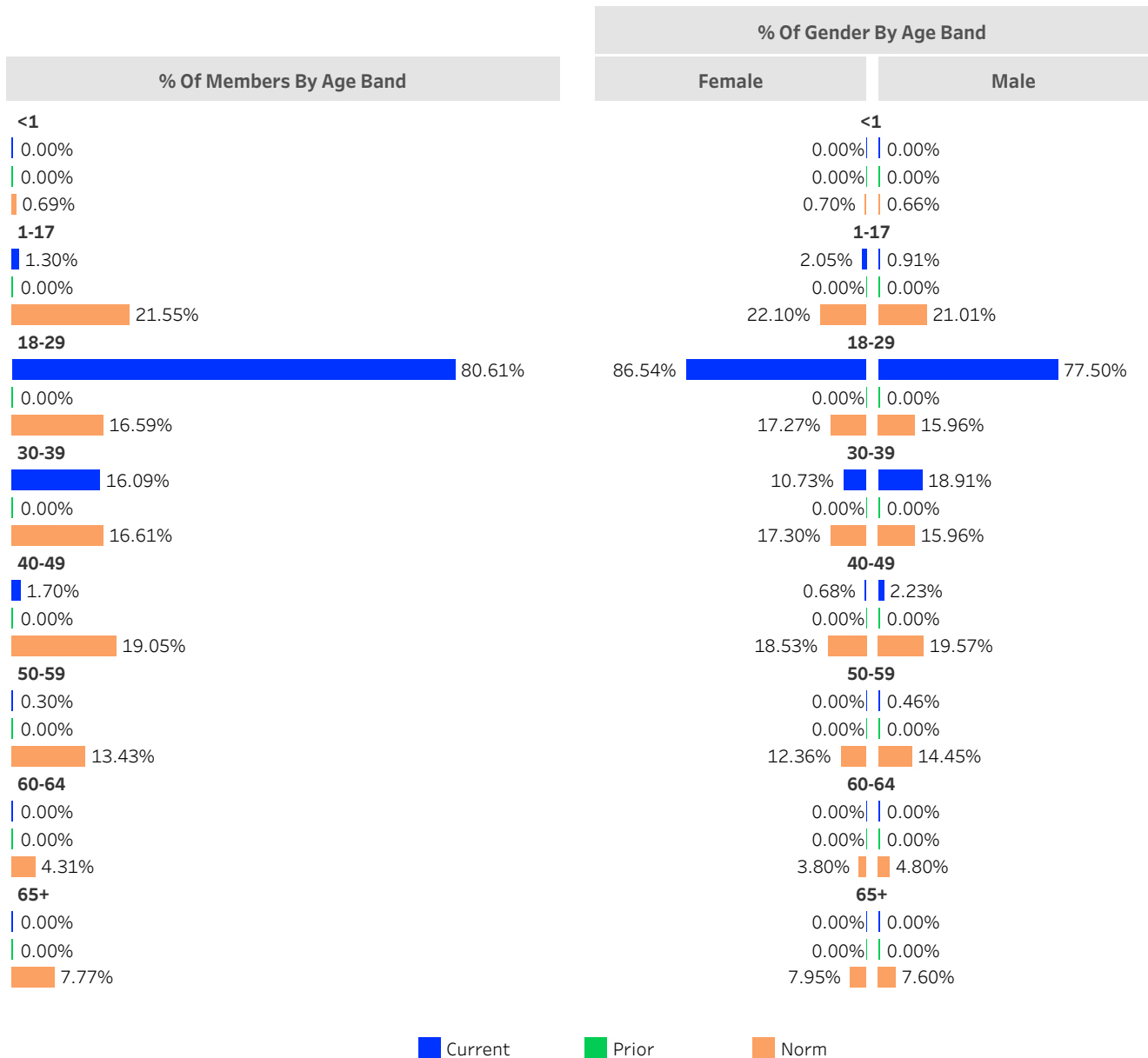
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Gender and Age Distribution

Sep 2025 - Mar 2026

Louisiana Tech University



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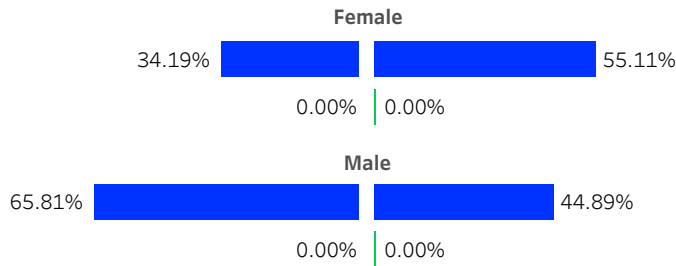
Membership and Spend by Demographic Profile

Sep 2025 - Mar 2026

Louisiana Tech University

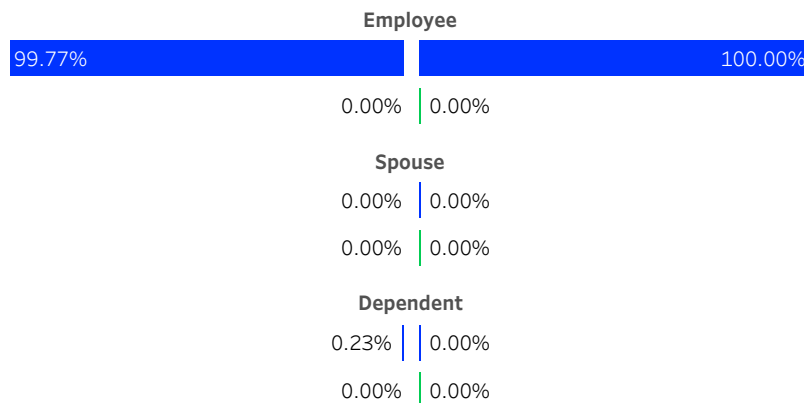
% Of Membership By Gender

% Of Spend By Gender



% Of Membership By Relationship Type

% Of Spend By Relationship Type



■ Current ■ Prior



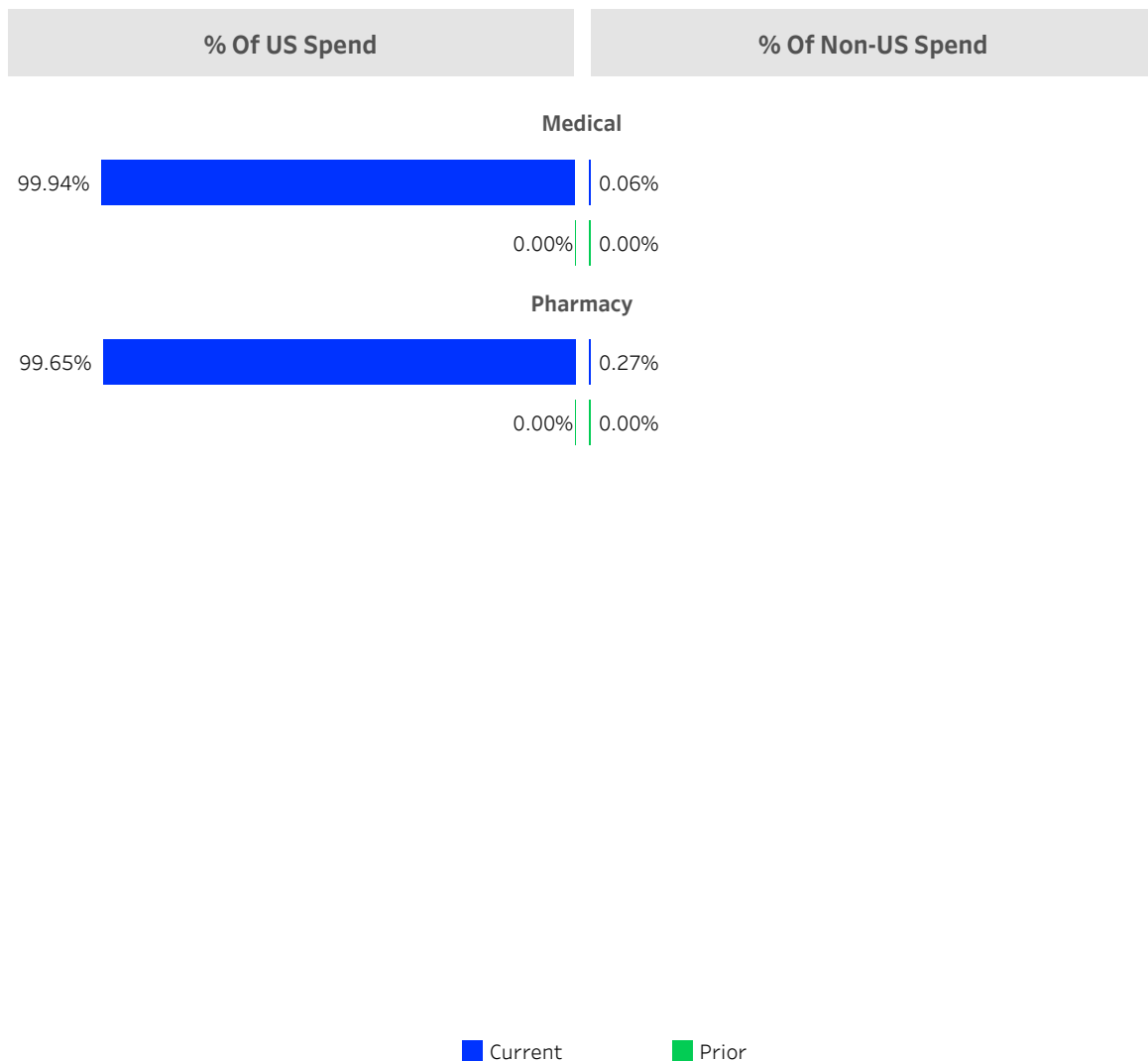
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US v Non-US Spend

Sep 2025 - Mar 2026

Louisiana Tech University





Member Location and Spend by Incurred Country

Sep 2025 - Mar 2026

Louisiana Tech University

Member Location



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428

EE Total

1

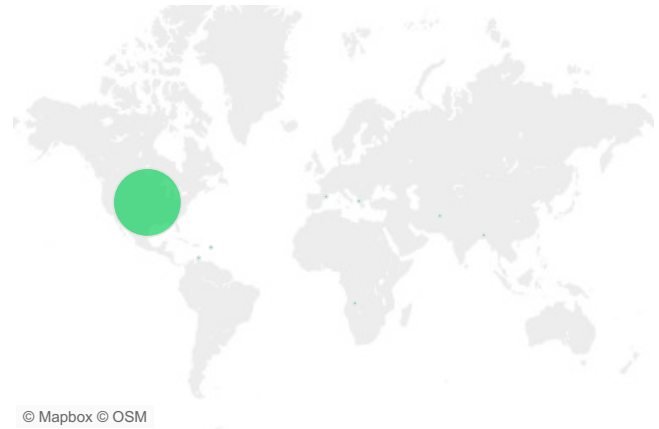
Dep Total

429

Total

Top 10 Member Location	Prior Rank	EE	Dep	Total	% Of Total
USA	233	428	1	429	100.00%
ABW	1	0	0	0	0.00%
AFG	2	0	0	0	0.00%
AGO	3	0	0	0	0.00%
AIA	4	0	0	0	0.00%
ALB	5	0	0	0	0.00%
AND	6	0	0	0	0.00%
ANT	7				0.00%
ARE	8	0	0	0	0.00%
ARG	9	0	0	0	0.00%

Spend By Incurred Country



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100.00%

EE Spend

Dep Spend

Top 10 Incurred Location	Prior Rank	% Of Claims
USA	-	99.93%
BGD	-	0.07%



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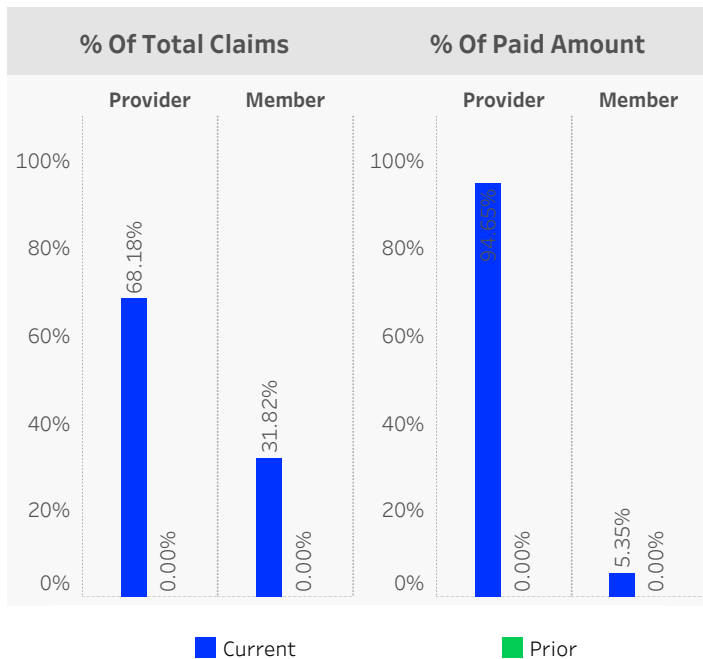


Network Utilization Summary

Sep 2025 - Mar 2026

Louisiana Tech University

% Of US Claims (Based On # Of Claims)	% Of US Claims (Based On Total Spend)	% US Claims In Network (Based On # Of Claims)	% US Claims In Network (Based On Total Spend)
99.63% Current ▲ 100.00%	99.93% Current ▲ 100.00%	90.63% Current ▲ 100.00%	88.96% Current ▲ 100.00%
Prior 0.00%	Prior 0.00%	Prior 0.00%	Prior 0.00%



CignaLinks Utilization By Region		
Region	Current	Prior
Africa	0.00%	0.00%
Australia	0.00%	0.00%
Brazil	0.00%	0.00%
Canada	0.00%	0.00%
China	0.00%	0.00%
Guam	0.00%	0.00%
Hong Kong	0.00%	0.00%
Middle East	0.00%	0.00%
Southeast Asia	0.00%	0.00%
Spain	0.00%	0.00%



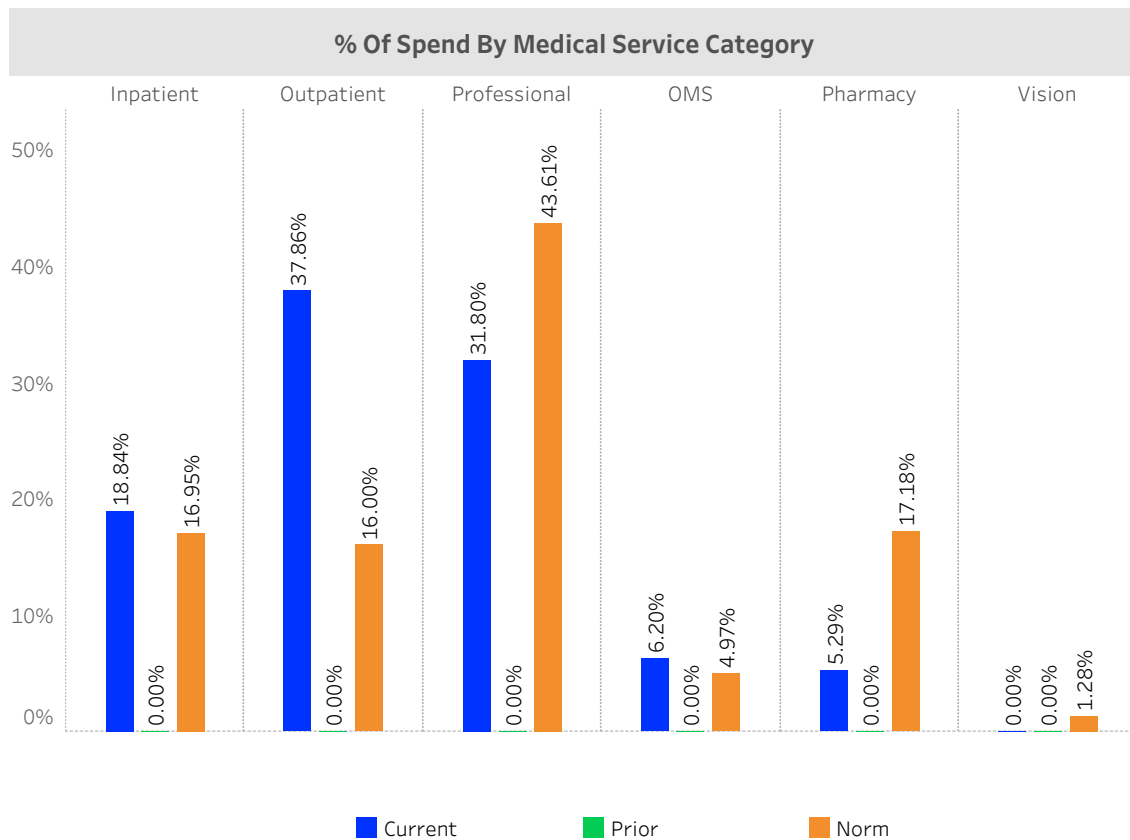
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Medical Service Category Distribution

Sep 2025 - Mar 2026

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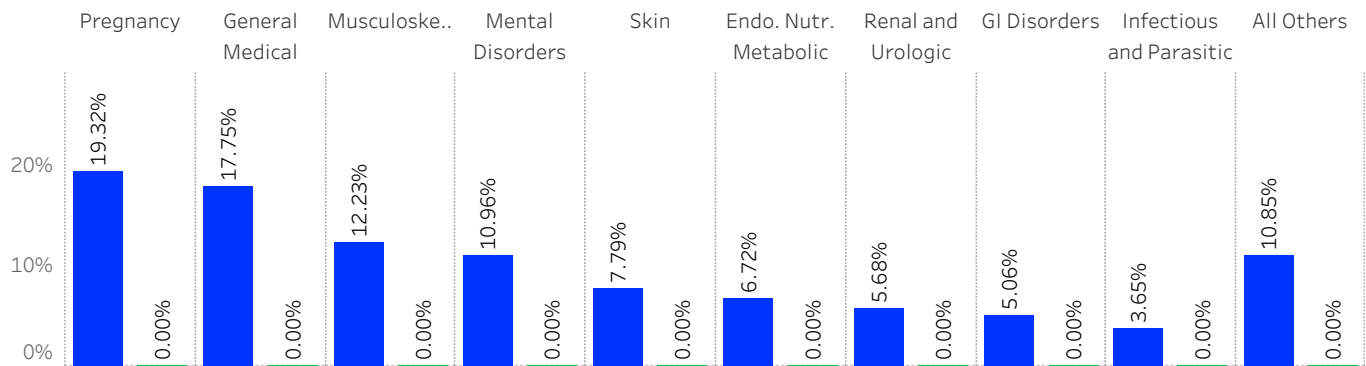


Medical Top Diagnostic Categories

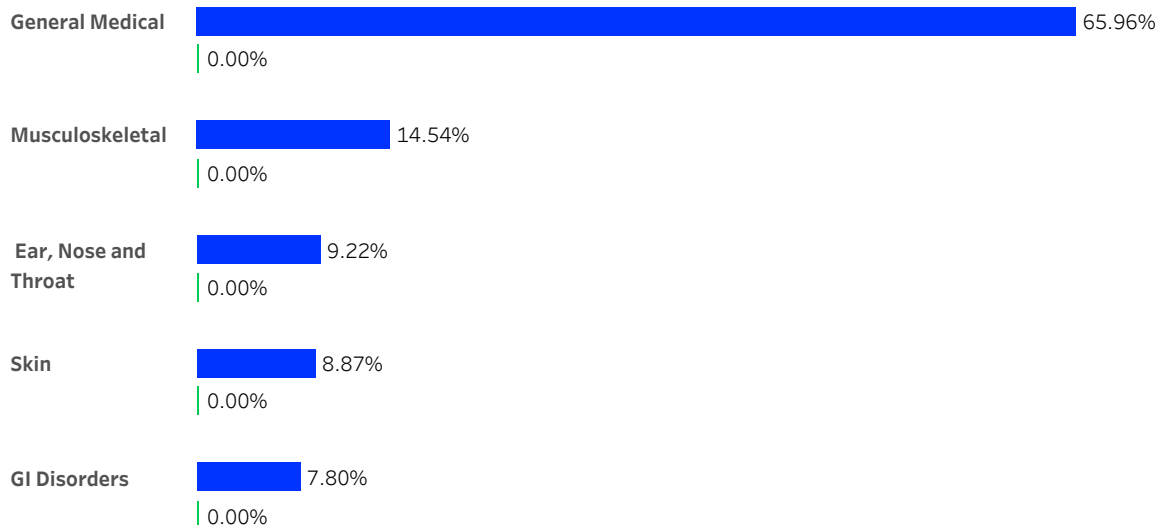
Sep 2025 - Mar 2026

Louisiana Tech University

% Of Spend By MDC



Top 5 Medical Condition: % Of Population



Current

Prior

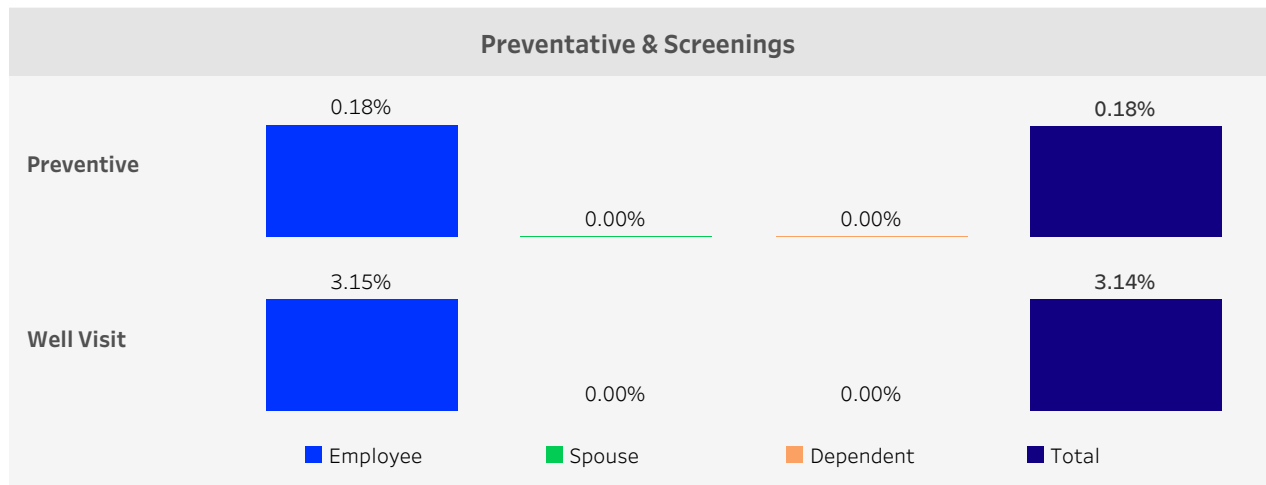
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Preventive Care Utilization

Sep 2025 - Mar 2026

Louisiana Tech University



Employees & Dependents		Current	Prior	Trend
Preventive Care Utilization	Employee	0.18%	0.00%	▲ 0.18%
	Spouse	0.00%	0.00%	→ 0.00%
	Dependent	0.00%	0.00%	→ 0.00%
	Total	0.18%	0.00%	▲ 0.18%
Well Visit Completion	Employee	3.15%	0.00%	→ 0.00%
	Spouse	0.00%	0.00%	→ 0.00%
	Dependent	0.00%	0.00%	→ 0.00%
	Total	3.14%	0.00%	→ 0.00%



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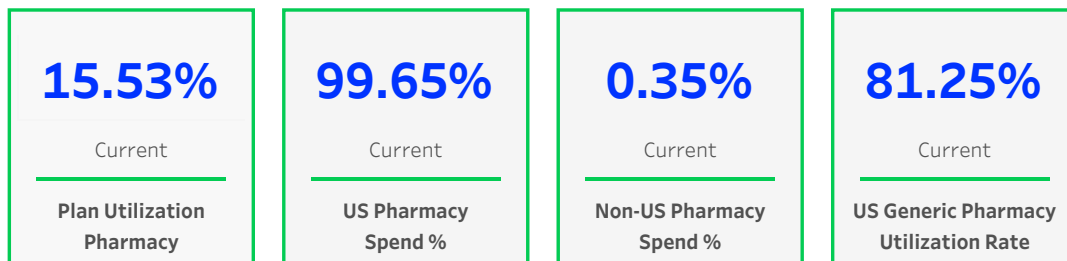


Pharmacy Key Metrics

Sep 2025 - Mar 2026

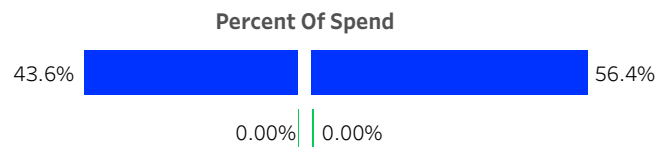
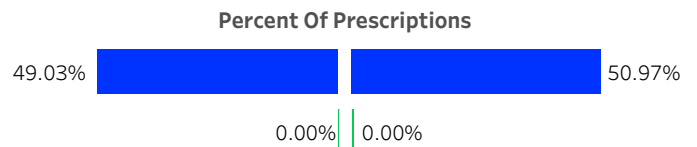
Louisiana Tech University

Membership Summary



Statistics By Gender

Female	Male



■ Current ■ Prior



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Addendum #1 - Attachment #10

Bid Number:	50012-563-26	Bid Title:	International Student Health Insurance



Cigna StudyWell®

Summary of Benefits for:
Louisiana Tech University
Policy Number: 10676A

Global Health Benefits

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Offered by Cigna Health and Life Insurance Company or its affiliates.



Insured and/or administered by:
Cigna Global Insurance Company Limited

Louisiana Tech University
Benefits at a Glance
Global Plan for all covered Members
Policy # 10676A
Plan Start Date September 1, 2025

This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

Cigna Healthcare, Global Health Benefits Customer Service		
Toll Free Telephone Number:	1.800.441.2668	
Direct Telephone:	1.302.797.3100 (collect calls accepted)	
Toll Free Fax Number:	1.800.243.6998	
Direct Fax Number:	001.302.797.3150	
Secure Website:	www.CignaEnvoy.com Registration is required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Healthcare P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Healthcare 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Annual Maximum	\$250,000		
Policy Year Deductible · Per Individual	\$0	\$200	\$400
· Per Family	\$0	\$400	\$800
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	75%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual	\$0	\$5,000	\$7,500
· Per Family	\$0	\$10,000	\$20,000



Global Medical Plan	
Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.
Certification Requirements - For services rendered inside the United States	
Precertification for inpatient and outpatient services received in the U.S. may be required. • Providers must call our toll-free number, 1.800.441.2668 to pre-certify services. • You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services. • Failure to obtain precertification may affect Out-of-Pocket costs. • This is a summary only and further details can be found in the certificate booklet.	



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit · Surgery Performed In the Physician's Office	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Student Health Center (if applicable)	Not Covered	100% not subject to deductible	100% not subject to deductible
Preventive Care · Routine Preventive Care · Policy Year Maximum: · Immunizations	Not Covered Not Covered	Not Covered Not Covered	Not Covered Not Covered
Travel Immunizations (Immunizations as required for travel)	Not Covered	Not Covered	Not Covered
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	Not Covered	Not Covered	Not Covered
Inpatient Hospital · Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate) · Inpatient Hospital Physician Visits/Consultations · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% 100% 100%	\$200 copay, then 100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Services · Outpatient Facility Services · Outpatient Professional Services	100% 100%	100% after deductible 100% after deductible	75% after deductible 75% after deductible
Emergency Room	100%	\$350 per visit copay, then 100% not subject to deductible	\$350 per visit copay, then 100% not subject to deductible
Urgent Care Services	100%	\$50 copay, then 100% not subject to deductible	75% after deductible
Ambulance	100%	100% after deductible	75% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Laboratory Services · Physician Office Visit · Outpatient Facility · Laboratory Services at an Independent Lab facility	100% 100% 100%	100% not subject to deductible 100% after deductible 100% after deductible	75% after deductible 75% after deductible 75% after deductible
Radiology Services · Physician Office Visit · Outpatient Facility	100% 100%	100% not subject to deductible 100% after deductible	75% after deductible 75% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) · Physician Office Visit · Inpatient Facility · Outpatient Facility	100% 100% 100%	\$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible	75% after deductible 75% after deductible 75% after deductible
Outpatient Therapy Services · Physician Office Visit · Outpatient Hospital Facility	100% 100%	\$40 copay, then 100% not subject to deductible \$40 copay, then 100% not subject to deductible	75% after deductible 75% after deductible
Policy Year Maximum:	20 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational, Cognitive, and Physical Therapy / Physiotherapy.			



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Chiropractic Care Policy Year Maximum:	Not Covered	Not Covered	Not Covered
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	100% after deductible	75% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	\$40 copay, then 100% not subject to deductible	75% after deductible
· Delivery – Facility			
· Inpatient Hospital	100%	\$200 copay, then 100% not subject to deductible	75% after deductible
· Birthing Center	100%	\$200 copay, then 100% not subject to deductible	75% after deductible



Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Infertility, Fertility and Conception Services - Physician Office Visit and Counseling - Lab and Radiology Tests - Inpatient Facility - Outpatient Facility	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered
Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Device / Aids	Not Covered	Not Covered	Not Covered
Dental Care Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth - Physician Office Visit - Inpatient Facility - Outpatient Facility Policy Year Maximum	100% 100% 100%	\$40 copay, then 100% not subject to deductible \$200 copay, then 100% not subject to deductible 100% after deductible \$1,000	75% after deductible 75% after deductible 75% after deductible
Mental Health - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder) - Inpatient Facility Maximum: (combined with Substance Use Disorder)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible
Substance Use Disorder - Physician Office Visit - Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health) - Inpatient Facility Maximum: (combined with Mental Health)	100% 100% 100%	\$40 copay, then 100% not subject to deductible 100% after deductible 10 Visits \$200 copay, then 100% not subject to deductible 30 Days	75% after deductible 75% after deductible 75% after deductible

Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	No Charge, not subject to plan deductible	
Purchased Inside the United States Only		
Benefit Highlights	Network Pharmacy (U.S. In-Network)	Non-Network Pharmacy (U.S. Out-of-Network)
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$20 copay	You pay 25% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$50 copay	You pay 25% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$75 copay	You pay 25% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply	
Tier 1 - Generic Drugs on the Prescription Drug List	No charge after you pay the \$60 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$150 copay	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$225 copay	In-Network coverage only



Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Performance 3-Tier
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
Utilization Management	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Legacy 3-Tier"	

Global Evacuation Plan	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses for approved services.
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of Other
Return of Dependent Children	One-way Airfare at Economy Rates to return dependent children to country of residence
Repatriation of Mortal Remains	100% coverage



Global Telehealth

Teladoc Health International	Global telehealth gives you no cost 24/7 access to licensed doctors for non-emergency health issues. Common outreaches include fever, rash, pain, non-emergency pediatric care, and more. Referrals to specialists and prescriptions available when medically necessary and locally permitted. Telephone or video consultations can be arranged through Cigna Envoy (cignaenvoy.com).

Global Accidental Death & Dismemberment

Member Benefit	A flat benefit amount of \$10,000
Reduction of Benefits	To 65% at age 65 and 50% at age 70; Terminate at Retirement
Scope of Coverage	24 Hour Coverage

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You can also contact Cigna Healthcare through the secure mailbox in [Cigna Envoy](#)[®].*

Contact us options

Toll-free telephone number	+1.800.441.2668
Toll-free TDD telephone number (for the hearing impaired)	+1.800.558.3604
Direct phone (collect calls accepted)	+1.302.746.3059
Toll-free facsimile number	+1.800.243.6998
Direct facsimile number (inside the U.S.)	+1.302.797.3150
Website	CignaEnvoy.com

Global Health Benefits



*Web-based tools, such as Cigna Envoy[®] are available for informational purposes only. These tools are not intended to be a substitute for medical care provided by a physician. The listing of a health care professional or facility in the mobile directories available through the Cigna Envoy mobile app does not guarantee that the services rendered by that professional or facility are covered under your benefits plan. Refer to your plan documents, or call the number listed on your ID card, for information about the services covered under your plan benefits. References to non-partnered organizations or companies, and/or their products, processes or services, do not necessarily constitute an endorsement or warranty thereof.

Product availability may vary by location and plan type and is subject to change. Products may not be available in all jurisdictions and are excluded where prohibited by law. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

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Participating Sponsor/Group:
Louisiana Tech University

MEDICAL BENEFITS (OPEN ACCESS
PLUS)
EMERGENCY MEDICAL EVACUATION
AND REPATRIATION BENEFITS

EFFECTIVE DATE: September 1, 2025

CN001
10676A
1770096

This document printed in November, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your group or Cigna.

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*Address: P.O. Box 155
Mill Court
La Charroterie
St Peter Port Guernsey GY1 4ET*

CIGNA GLOBAL INSURANCE COMPANY LIMITED

(herein called Cigna) certifies that it insures certain Members for the benefits provided by the following policy(s):

POLICYHOLDER: CIGNA GLOBAL WELLBEING SOLUTIONS LIMITED

PARTICIPATING SPONSOR/GROUP: Louisiana Tech University

GROUP POLICY(S) — COVERAGE

10676A – MEDICAL BENEFITS (OPEN ACCESS PLUS)

10676A – EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS

EFFECTIVE DATE: September 1, 2025

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

All benefits payable under this Policy will be made in United States Dollars.

A handwritten signature in black ink, appearing to read 'Jae Lay', with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.



Special Plan Provisions

When you select a Participating Provider, the cost for medical services provided will be less than when you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. For a list of Participating Providers in your area, visit www.cignaenvoy.com or contact customer service at the phone number listed on the back of your ID card. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction with Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card. In addition, the Group, a claim

office or a utilization review program (see the Pre-Admission Certification (PAC)/Continued Stay Review (CSR) section of your certificate) may refer an individual for Case Management.

- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent are contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well-being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact us for details regarding any such arrangements.



Important Information

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility.
- pregnant and undergoing treatment for the pregnancy from the provider or facility.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If applicable, Cigna will notify you of your continuity of care options.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, pharmacies, and dental practitioners affiliated or contracted with Cigna or an organization contracting on its behalf.

How To File Your Claim

There's no paperwork for In-Network care. Just show your ID card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network and International claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms at www.cignaenvoy.com.

CLAIM REMINDERS

- BE SURE TO USE YOUR ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR ID CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network and International Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for Out-of-Network benefits or for International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for Out-of-Network benefits or for International benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Members as determined by the Group;
- you pay any required contribution; and
- you're traveling outside your country of residence for study abroad program

If you were previously insured and your insurance ceased, you must satisfy the New Member Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Members, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Members within one year after your insurance ceased.

Initial Member Group: You are in the Initial Member Group if you are employed in a class of Members on the date that class of Members becomes a Class of Eligible Members as determined by the Group.

New Member Group: You are in the New Member Group if you are not in the Initial Member Group.



Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of;

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Member Group: A period of time as determined by the Group.

New Member Group: A period of time as determined by the Group.

Classes of Eligible Members

- Students: each member identified as a student by the Participating Group.

Persons for whom coverage is prohibited under applicable law or sanction rules will not be considered eligible under this plan.

Effective Date of Member Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date when you become eligible for Member Insurance and your Dependent(s) become eligible for Dependent Insurance and when you elect it by signing an approved payroll deduction or enrollment form, as applicable.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Important Information About Your Medical Plan U.S.

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care inside the United States (in-network and out-of-network) and internationally (outside the United States). To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance, if any.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your ID card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that plan year.

Contract Year

Contract Year means a twelve month period beginning on each 09/01.

Out-of-Pocket-Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100% for the rest of that plan year.

- Coinsurance, if any
- Plan Deductible
- Copayments
- Prescription Drug Copayments and Coinsurance, if any

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties
- Provider charges in excess of the Maximum Reimbursable Charge



Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate between In-Network, Out-of-Network and International. All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In-Network, Out-of-Network and International unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in a payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Lifetime Maximum	Unlimited		
Annual Maximum	\$250,000		
The Percentage of Covered Expenses the Plan Pays See Definitions section for an explanation of Maximum Reimbursable Charge	100%	75% of the Maximum Reimbursable Charge	100% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Contract Year Deductible Individual Family Family Calculation Individual Calculation Family members must meet only their individual Deductible and then their claims will be covered under the plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the plan Coinsurance.	\$200 per person \$400 per family	\$400 per person \$800 per family	\$0 per person \$0 per family
Combined Medical/Pharmacy Contract Year Deductible	No	Yes	No
Contract Year Out-of-Pocket Maximum Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members must meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$5,000 per person \$10,000 per family	\$7,500 per person \$20,000 per family	\$0 per person \$0 per family
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Emergency Medical Evacuation & Repatriation Benefit Maximum: \$100,000			
Emergency Medical Evacuation	100%	100%	100%
Repatriation Following a Medical Evacuation	100%	100%	100%
Primary Repatriation to the Permanent Residence after a Serious Medical Event	100%	100%	100%
Repatriation of Mortal Remains	100%	100%	100%
Emergency Family Travel Arrangements and Confinement Visitation	100%	100%	100%
Return of Dependent Children	100%	100%	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Physician's Services			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Consultant and Referral Physician's Services	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Surgery Performed In the Physician's Office			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Second Opinion Consultations (provided on a voluntary basis)			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Allergy Treatment/Injections			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Student Health Center	100%	100% of the Maximum Reimbursable Charge	Not Covered
Inpatient Hospital - Facility Services	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate. (Private room covered outside the United States only if no semi-private room equivalent is available).
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Hospital Physician's Visits/Consultations	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Inpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Ambulance	Plan Deductible, then 100%	Plan Deductible, then 100% of the Maximum Reimbursable Charge	100%
Laboratory Services			
Physician Office Visit	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Laboratory Services at an Independent Lab facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Radiology Services			
Physician Office Visit	100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Radiological Imaging (i.e. , MRIs, MRAs, CAT Scans and PET Scans) The scan Copay applies per day Physician Office Visit Inpatient Facility Outpatient Facility	\$200 scan Copay, then 100% \$200 per admission Copay, then 100% \$200 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%
Outpatient Therapy Services Physician Office Visit Outpatient Hospital Facility Contract Year Maximum: 20 days for all therapies combined Includes: Cardiac Rehab Physical / Physio Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Applied Behavior Analysis (ABA Therapy) Combined Contract Year Maximum: 30 days	\$40 per visit Copay, then 100% \$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene Therapy is only covered in the United States when received at a provider contracted with Cigna for the specific gene therapy product and related services.			
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	\$200 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	100%
Travel Maximum \$10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced cellular therapy is only covered in the United States when received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services.			
Advanced Cellular Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	\$200 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	100%
Advanced Cellular Therapy Travel Maximum: \$10,000 per episode of advanced cellular therapy	100%	In-Network Coverage Only	In-Network Coverage Only
(Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Maternity Care Services			
Initial Visit to Confirm Pregnancy Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Delivery - Facility Inpatient Hospital	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Birthing Center Contract Year Maximum: Unlimited	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Abortion Includes elective and non-elective procedures			
Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Infertility, Fertility and Conception Services	Not Covered	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants Physician Office Visit Inpatient Facility Travel Maximum: \$10,000 per transplant	\$40 per visit Copay, then 100% \$200 per admission Copay, then 100% 100% (only available when using Cigna LifeSOURCE Transplant Network® facilities)	In-Network Coverage Only In-Network Coverage Only In-Network Coverage Only	100% 100% In-Network Coverage Only
Durable Medical Equipment Contract Year Maximum: \$700	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Insulin Pumps Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Blood Glucose Meters Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Diabetic Supplies	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Nutritional Counseling Contract Year Maximum: 3 visits; the visit limit does not apply to treatment of diabetes Physician Office Visit Inpatient Facility Outpatient Facility	\$40 per visit Copay, then 100% \$200 per admission Copay, then 100% Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Nutritional Formulas Unlimited	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Genetic Counseling Contract Year Maximum: 3 visits; for counseling, pre- and post-genetic testing Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an Injury to teeth. Physician Office Visit	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Inpatient Facility	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Facility Contract Year Maximum: \$1,000	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Alternative Therapies and Non-traditional Medical Services Herbalist, Massage Therapist, Naturopath Physician Office Visit Combined Contract Year Maximum: \$1,000	Not Covered	Not Covered	100%
Routine Foot Disorders Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.			
Mental Health Inpatient Includes Acute Inpatient and Residential Treatment Contract Year Maximum: 30 Days Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy; medication management Contract Year Maximum: 10 Visits Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Transcranial Magnetic Stimulation (TMS), etc. Contract Year Maximum: 10 Visits	\$200 per admission Copay, then 100% \$40 per visit Copay, then 100% Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge Plan Deductible, then 75% of the Maximum Reimbursable Charge	100% 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Substance Use Disorder			
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Contract Year Maximum: 30 Days	\$200 per admission Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy, medication management Contract Year Maximum: 10 Visits	\$40 per visit Copay, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%
Outpatient - All Other Services Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc. Contract Year Maximum: 10 Visits	Plan Deductible, then 100%	Plan Deductible, then 75% of the Maximum Reimbursable Charge	100%

Certification Requirements U.S. Out-of-Network For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient; except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements - U.S. Out of Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility, or a Physician's office. You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services and should be

requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Diagnostic Testing, and Outpatient Procedures

Including, but not limited to:

- advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Medical Pharmaceuticals.
- radiation therapy.

Prior Authorization/Pre-Authorized U.S.

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- radiation therapy.
- transplant services.



Coverage includes immediate access, without Prior Authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna and that are not otherwise excluded from coverage by the terms of this policy, and
- as determined by Cigna, Medically Necessary Covered Expenses may also include charges for generally accepted medical standards of care and practice.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.

Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and

laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.

- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for the treatment of diabetes as recommended in writing or prescribed by a Physician or Other Health Professional, including:
 - insulin pumps, blood glucose meters and diabetes self-management training;
 - alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips; and
 - insulin and pharmacological agents for controlling blood sugar.
- charges for chronic care management services.
- charges for treatment of autism spectrum disorder including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for Medically Necessary specialized treatment and support to secure access to dental care for children under age 21 with severe disabilities due to significant mental or physical condition, illness or disease.
- charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment,

diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider legally allowed to practice in the state or country and practicing within the health care provider's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health care provider is at a distant site.

- **Distant site** means a site at which a health care provider legally allowed to practice in the state or country is located while providing health care services by means of telemedicine or telehealth.
- **Originating site** means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth.
- **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Genetic Counseling

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for genetic testing. May be performed prior to and/or following the genetic test.

Nutritional Counseling

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas and foods, low protein modified formulas and modified food products, consumed or administered enterally (via tube or orally), which are prescribed as Medically Necessary by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism), and the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), when administered under the direction of a Physician.

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Alternative Therapies and Non-traditional Medical Services - Outside the U.S.

Charges for Alternative Therapies and Non-traditional medical services are limited to the amount shown in The Schedule. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, Naturopath or Massage Therapist for Massage Therapy, when these services are provided for a covered condition outside the U.S. in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is Medically Necessary, cost-effective, and provided in an appropriate setting.

Mental Health and Substance Use Disorder Services

The plan covers charges for mental health and substance use disorder services.

Mental Health Disorders are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

Substance Use Disorders involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.

- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)

Mental Health Acute Inpatient Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

Mental Health Residential Treatment Services are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center.

Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)

Outpatient Mental Health Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential

Treatment Center, for evaluation and treatment of a Mental Health Disorder.

Mental Health Partial Hospitalization Services are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Mental Health Intensive Outpatient Services are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)

Acute Inpatient Detoxification Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

Substance Use Disorder Inpatient Treatment Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Substance Use Disorder Residential Treatment Center.



Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)

Outpatient Substance Use Disorder Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

Substance Use Disorder Partial Hospitalization Services are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Substance Use Disorder Intensive Outpatient Services are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Substance Use Disorder Detoxification Services are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

Outpatient Therapy Services

Charges for the following therapy services when provided as part of a program of treatment: **Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Breast Reconstruction

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-

diseased breast to produce symmetrical appearance. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Transplant Services and Related Specialty Care

- charges approved by medical management for human organ and tissue transplant services including solid organ and bone marrow/stem cell procedures are covered subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered at the U.S. In-Network level when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities in the United States specifically contracted with Cigna for the requested transplant services and related specialty care services are payable at the U.S. In-Network level.
- Transplant services and related specialty care services received outside the United States are covered at the International level.
- Transplant services and related specialty care services received at any other facility, including non-Participating

Provider facilities and Participating Provider facilities in the United States not specifically contracted with Cigna for the requested transplant services and related specialty care services, are not covered.

- Cornea transplants received at a facility in the United States, that is specifically contracted with Cigna for this type of transplant are payable at the U.S. In-Network level.

Charges for gene therapy products and services directly related to their administration are not covered under the Transplant Services and Related Specialty Care benefit.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services In-Network coverage only

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not

related to you, but actively involved as your caregiver who is at least 18 years of age.

- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant and Related Specialty Care Services and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donors costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the U. S. In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider in the United States that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced cellular therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an inpatient setting, outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions.



Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product.

Utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

For a complete list of covered Medical Pharmaceuticals visit the website shown on your ID card or call the number on the back of your ID Card.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in

part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at United States In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other United States facilities are not covered.

Gene therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Health Care Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
 - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
 - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover **any** of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
 - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
 - an item or service that is not used in the direct clinical management of the individual;
 - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
 - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
 - mileage reimbursement for driving a personal vehicle;
 - lodging;
 - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.



Emergency Medical Evacuation and Repatriation Benefits

Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna, and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

If you or your Dependent suffer a medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You or your Dependent must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to the specific Medical Necessity of each case.

Repatriation Following a Medical Evacuation

Covered Expenses

Following any covered emergency medical evacuation, Cigna will pay for one of the following:

- if it is deemed Medically Necessary and appropriate by the Cigna Medical Director, you or your Dependent will be transferred to your permanent residence via a one-way economy airfare; or
- you or your Dependent will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Primary Repatriation to the Permanent Residence after a Serious Medical Event

Following a Serious Medical Event, if it is deemed Medically Necessary and appropriate by the Cigna Medical Director, Cigna may pay for you or your Dependent to be transferred to your permanent residence via a one-way economy airfare.

If the Cigna Medical Director determines that transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, determines a mode of transport other than economy class seating on a commercial

aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the Home Country will be covered. In addition, assistance will be provided by Cigna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you or your Dependent are expected to require hospitalization in excess of 3 days at the location to which you will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

Exclusions

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna, or its designee.
- non-emergency routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you.
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency medical evacuation or repatriation or a Primary Repatriation to the Permanent Residence after a Serious Medical Event.
- medical care or services scheduled for a member or a providers convenience which are not considered an emergency or a Serious Medical Event.
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- services provided for which no charge is normally made.
- expenses incurred while serving in the armed forces of another country.



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- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation.
 - services provided other than those indicated in this certificate.
 - housing/lodging or accommodations, meals or travel related expenses.
 - hotel and accommodations for covered Dependents post discharge or while awaiting fitness to fly approval.
 - Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
 - death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
 - claim payments that are illegal under applicable law.



Prescription Drug Benefits

Inside the United States

The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies in the U.S. as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

Supplemental Discount Programs

You and your Dependents will pay 100% of the cost of any Prescription Drug Products excluded from coverage under this plan. The amount you and your Dependent pay for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Copayments (Copay)

Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
	United States	United States
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Contract Year Deductible Individual Family	\$0 \$0	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the “Patient Assurance Program”. As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Contract Year Out-Of-Pocket Maximum Individual Family Maximum	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS		NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Network Pharmacy or home delivery Network Pharmacy.			
Immunizations and Contraceptives Note: Certain Immunizations and Contraceptives are payable at 100% when purchased from a Network US Pharmacy.			
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy	
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$20 Copay	25% after plan Deductible	
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$50 Copay	25% after plan Deductible	
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$75 Copay	25% after plan Deductible	
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy	
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.			
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$60 Copay	25% after plan Deductible	
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$150 Copay	25% after plan Deductible	
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$225 Copay	25% after plan Deductible	

BENEFIT HIGHLIGHTS		NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy	
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Network Pharmacies.			
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$60 Copay	In-network coverage only	
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$150 Copay	In-network coverage only	
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$225 Copay	In-network coverage only	

Prescription Drug Benefits - U.S.

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations and Exclusions are provided below and are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on, which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, or Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your

Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier coverage status, utilization management, or other coverage limitations for a Prescription Drug Product.

Limitations

For most Prescription Drug Products you and your Dependent pay only the cost sharing detailed in The Schedule of Prescription Drug Benefits. However, in the event you or your Dependent insist on a more expensive Brand Drug where a Therapeutic Equivalent Generic Drug is available, you will be financially responsible for an Ancillary Charge, in addition to any required Brand Drug Copayment and/or Coinsurance. In this case, the Ancillary Charge will not apply to your Deductible, if any, or Out-of-Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.



Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. It is not necessary to obtain prior authorization in an emergency situation for a 72 hour supply of a non-controlled substance. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. If a prescriber indicates on the prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, a reauthorization for the same prescription medication will not be required more frequently than every 12 months. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies the patient for a step therapy exception. If the exception request is for a patient that is stable for the medical condition under consideration while on a Prescription Drug Product prescribed by the patient's health care provider, or prescribed under the patient's current or a previous insurance or health benefit plan, a step therapy determination will be considered granted until a step therapy determination is issued.

We will respond to the exception request with our decision within two (2) business days of receipt of the exception request. In the event we do not respond to an exception request within two (2) days, the exception request will be granted.



In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request. In the event we do not respond to an exception request within 24 hours for emergency circumstances, the exception request will be granted.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are beginning a therapy regimen on a Specialty Prescription Drug Product, we may limit your coverage for the initial Prescription Order or Refill to multiple, separate fills of less than the total days' supply set forth in The Schedule. If applicable, you will pay a pro-rated Coinsurance or Copayment amount for each such supply.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may receive reduced or no coverage for the Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New

Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Deductible

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule, if any. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest of the following amounts:

- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

The Schedule sets forth your costs for covered Prescription Drug Products after you have satisfied the Deductible amount.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a



Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy shall be determined by applying any applicable Deductible, non-Network Pharmacy Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a non-Network Pharmacy.

Any reimbursement due to you for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Copayment, Coinsurance, or other cost-sharing payment you owe.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for you or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, and fade cream products.
- Prescription Drug Products used for the treatment of infertility.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of



disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.

- prescription smoking cessation products.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan or wish to dispute the amount you were charged. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product. If you believe that the amount of any applicable Copayment, Coinsurance and/or Deductible you were charged was incorrect, to dispute the accuracy of the amount you were charged you must submit a claim for reimbursement according to the applicable claim filing procedures for postservice claims.

When you purchase a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit



Prescription Drug Benefits
International
Outside the United States
The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies outside the U.S. as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Contraceptives

Note: Contraceptive devices and oral contraceptives are payable as shown in The Schedule.

BENEFIT HIGHLIGHTS		INTERNATIONAL PHARMACY Outside the United States	
Lifetime Maximum		Refer to the Medical Benefits Schedule	
Contract Year Deductible			
Individual		\$0	
Family		\$0	
Contract Year Out-of-Pocket Maximum			
Individual		Refer to the Medical Benefits Schedule	
Family		Refer to the Medical Benefits Schedule	
Prescription Drug Products at Pharmacies Outside the United States		The amount you are required to pay	
		No charge	

Prescription Drug Benefits - International

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy outside the United States. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy outside the United States for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule.

Coverage also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an emergency medical condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a Pharmacy shall be determined by applying any applicable Deductible,

Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a Pharmacy. Any reimbursement due to you for a covered Prescription Drug Product dispensed by a Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Coinsurance, or other cost-sharing payment you owe.

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products purchased outside the United States:

- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products except where covered under the medical benefits.
- Prescription Drug Products furnished by the local, state or federal government.
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products used for the treatment of infertility.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.



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- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
 - medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or unless the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
 - certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
 - any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
 - prescription smoking cessation products.
 - medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
 - immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions.
 - medications that are not FDA-approved for any indication.
 - Prescription Drug Products classified as gene therapy.

Reimbursement/Filing a Claim

When you or your Dependents purchase covered Prescription Drug Products through a Pharmacy outside the United States, you must pay the Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.



Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- for charges made for Home Health Care Services.
- for charges made for Hospice Care Services.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment.
- Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action which occurs in the Member's Country of Citizenship.
- Injury or Sickness that results, directly or indirectly from: nuclear fission, fusion or radioactivity; nuclear, biological and chemical weapons and/or devices; or attacks on, or sabotage of, facilities and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents which occurs in the Member's Country of Citizenship.
- charges which you are not obligated to pay and/or for which you are not billed or for which you would not have been billed. This exclusion includes, but is not limited to:
 - any instance where Cigna determines that a provider or pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
 - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
- deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
- reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.
- not considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved

labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature and is considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the "Reconstructive Surgery" benefits: macromastia surgery; gynecomastia surgery; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) disorders.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an Injury to teeth are covered provided a continuous course of dental treatment is started within six months of the Injury.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government

licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.

- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth

announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as covered under this plan as shown in the Covered Expenses section.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. A hearing aid is any device that amplifies sound.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books, except as shown in the Covered Expenses section for treatment of autism.
- corrective lenses, eyeglass lenses and frames, contact lenses and associated services (exams and fitting), except the initial prescribed set or pair after treatment of keratoconus or following cataract surgery.
- routine refractions, and eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- acupuncture.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs and weight loss programs.
- charges for smoking cessation treatment.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in

anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

- blood administration for the purpose of general improvement in physical condition.
- health and beauty aids, cosmetics and dietary supplements.
- enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except as specifically provided in the “Enteral Nutrition” benefit.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker’s compensation or similar laws.
- the cost of treatment or services that are provided without charge by a Student Health Center or rendered by a person employed by the Participating Sponsor/Group, including, but not limited to team doctors and trainers, or other services performed at no cost.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- to the extent that payment is unlawful or prohibited by applicable sanctions rules.
- for elective or pre-scheduled treatment in sanctioned countries.
- for any person whom Cigna considers to be “ordinarily resident” in a sanctioned country. A person is considered “ordinarily resident” if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.
- for charges made for any service that is not covered by the terms of this policy or for coverage declined, or otherwise not elected by you, at enrollment.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- any charges related to care provided through a public program.
- to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.



- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs, or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's Family.
- for claim payments that are illegal under applicable law.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under any government health insurance plan.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the

Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:



- The Plan that covers you as an enrollee or a member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or member;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the parent not having custody of the child, and
 - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active member or retiree (or as that member's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans are not more than 100% of the total of all Allowable Expenses.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Expenses for Which a Third Party May be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), occupational disease law, any employers' liability insurance or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.



Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of

recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits

Medical

Assignment and Payment of Benefits

You may authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize



the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment within twenty-four (24) months after the payment is made. The 24 month limit will not apply if there is reasonable belief of fraud, abuse or other intentional misconduct, or if required by a state or federal government plan. In addition, your acceptance of benefits under this plan and/or assignment of Medical, Dental and Vision benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Termination of Insurance – Members

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by the Group. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date the Group stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which the Group stops paying premium for you or otherwise cancels the insurance.

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent insurance.
- the date Dependent insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.



Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums, and you or your Dependent is Confined in a Hospital on that date), Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the Hospital Confinement;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

You are entitled to receive free upon request access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be notified of the final decision in a timely manner, as described in your plan materials.

If you are still not satisfied with our final decision to your complaint or appeal, you can refer your complaint or appeal to the Channel Islands Financial Ombudsman Service at the address below:

The Channel Islands Financial Ombudsman (CIFO)
PO Box 114
Jersey, Channel Islands
JE4 9QG
Telephone: +44 (0)1534 748610
Fax: +44 (0)1534 747629
Email: enquiries@ci-fo.org
Website www.ci-fo.org

When You Have an Appeal or Complaint

If you have questions, disagree with the determination of a claim, or have a complaint, you may contact Cigna at the address indicated below. A written request for a claim review must be sent in writing within 365 days of receipt of a denial notice to:

Cigna

Attn: Appeals & Complaints

P.O. Box 15800

Wilmington, DE 19850 USA

For a claim review, you should state the reason(s) why you feel your claim should have been approved. Send a copy of the denial along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. For questions, please contact the **Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).**

It is important to include your Name, Group Number, Member/Patient ID Number, Name of the patient and relationship, and "Attention: Appeals" on all supporting documents.

Definitions

Active Service/Enrollment

You will be considered in Active Service/Enrollment:

- on any of your Group's scheduled work/enrolled days if you are performing the regular duties of your work on a full-time basis or studying as determined by your group on that day either at your Group's place of business or academic institution or at some location to which you are required to travel for your Group.
- on a day which is not one of your Group's scheduled work/academic days if you were in Active Service on the preceding scheduled work day.

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

Chiroprapist

See Podiatrist



Cigna LifeSOURCE Transplant Network®

The Cigna LifeSOURCE Transplant Network® consists of designated In-Network facilities that have met quality and cost criteria and have contracted with Cigna LifeSOURCE to provide transplant services as a Participating Provider in the Cigna LifeSOURCE Transplant Network®. In order to be considered a facility in the Cigna LifeSOURCE Transplant Network®, the facility must be a designated program for the specific type of transplant requested.

Country of Citizenship

Country of Citizenship is the nation of the Member or Dependents' birth or the country in which they have subsequently been naturalized or granted legal citizenship or recognition.

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is:
 - less than 26 years old.

- 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability, or intellectual disabilities or a physical handicap which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as a Member will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Member coverage. A child under age 26 may be covered as either a Member or as a Dependent child. You cannot be covered as a Member while also covered as a Dependent of a Member.

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

Emergency Services

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the



staff and facilities available at the Hospital, to stabilize the patient.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

Group

The term Group means an eligible organization or plan sponsor.

Herbalist

The term Herbalist means a non-medical practitioner who specializes in treating disorders with natural remedies derived exclusively from plant materials.

Home Country

Home Country is the nation in which the Member or Dependents have their permanent place of residence prior to an expatriate assignment and/or the indefinite intention to reside post assignment.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;



- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, or is appropriately accredited where located as determined by Cigna; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician; and
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Drug Product by calling member services at the telephone number on your ID card.

Massage Therapist

The term Massage Therapist means a person who is licensed to apply manipulation, methodical pressure, friction and kneading to the body.

Maximum Reimbursable Charge - Medical Services in the United States

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay an Out-of-Network health care provider for a Covered Expense. Your applicable Out-of-Network Copayment, Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, Out-of-Network providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from an Out-of-Network provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If an Out-of-Network provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the Out-of-Network allowable amount for a Covered Expense. An Out-of-Network provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party vendors that establishes the rate the Out-of-Network provider is willing to accept as payment for the Out-of-Network Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If an Out-of-Network provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the provider's normal charge for a similar service or supply; or
- a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge is 150%.

The Maximum Reimbursable Charge is subject to all other benefit limitations and exclusions and Cigna's applicable Coverage Policies, Reimbursement Policies, and other coding and payment methodologies. Additional information about



how Cigna determines the Maximum Reimbursable Charge is available upon request.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Copayment, Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

Maximum Reimbursable Charge – Medical and Pharmacy Services Outside the United States

Maximum Reimbursable Charge for services outside the United States is determined based on:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- Reasonable and Customary expenses. Medical expenses will be considered Reasonable and Customary if they (i) correspond to the normal charge for the service by providers in the locality where the service is rendered or performed; and (ii) the services are provided according to established clinical and medical practice.

Telehealth expenses should not exceed the cost of an equivalent face-to-face consultation.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable payment methodologies determined by Cigna.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

Cigna is not obligated to pay excessive charges.

Medicaid – U.S.

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or Other Health Professional within the

scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on, the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia, peer-reviewed, evidence-based scientific literature or guidelines and generally accepted medical standards of care and practice.

Medicare - U.S.

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.



Member

The term means faculty, chaperone, fellows, volunteer, and student of a school who is in study abroad program, who is currently enrolled and for whom premiums have been paid of the Group outside their country of residence.

Naturopath

The term Naturopath means a non-medical practitioner who specializes in treating conditions by making reforms to the diet and lifestyle of the patient.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under the Group's plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.", "L.P.N." or "L.V.N.".

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is appropriately licensed and/or certified by the appropriate authorizing agency to deliver Medically Necessary services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.



Participating Provider - Medical

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies in the U.S., the charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the charges for which are Covered Expenses. Covered services and/or supplies received from Participating Providers are considered In-Network.

Participating School

The term Participating School means a Higher Education participating in the Trust to which this policy is issued.

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Podiatrist

The term Podiatrist means a licensed practitioner responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot. A Podiatrist performs surgical procedures, prescribes corrective devices, drugs and physical therapy.

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

Prescription Drug Charge - International and U.S. Non-Network Pharmacies

The Prescription Drug Charge is the amount for a specific covered Prescription Drug Product dispensed at a Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax.

Prescription Drug Charge - U.S. Network Pharmacies

The Prescription Drug Charge is the amount established by Cigna for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax. This amount is established in connection with the overall Prescription Drug Product pricing implemented in relation to the premium negotiated between Cigna and the plan sponsor.

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by the Group as part of the plan. The list is subject to periodic review and change and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug



Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- certain durable products and supplies that support drug therapy;
- certain diagnostic testing and screening services that support drug therapy;
- certain medication consultation and other medication administration services that support drug therapy; and
- certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

The following diabetic supplies are also included under this definition: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been selected by you and is contracted as a Primary Care Physician, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any

other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness – Medical

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or



restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Student Health Center

The term means primary care clinics based on primary or secondary school campuses in the United States.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of twelve months or less to live, as diagnosed by a Physician.

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Usual and Customary (U&C) Charge - Prescription Drugs

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.



CIGNA GLOBAL HEALTH BENEFITS EUROPE DATA PROTECTION NOTICE

As a provider of quality healthcare around the world, our customers and clients expect us to carefully handle and protect the Personal Information (as defined below) they share with us.

You are receiving this Data Protection Notice either because your group has signed an agreement with us, as an insurance company, to provide you, directly or through our partners, with international health insurance cover and other additional covers and services as it may apply (referred to in this Data Protection Notice as the “Services”), or you otherwise benefit from our Services (for example, as a dependent).

In order to provide our Services to you, we will collect and use your Personal Information. This Data Protection Notice explains how and why we do this, and outlines your rights in relation to your Personal Information.

Depending on the specific terms and conditions of our insurance agreement with the group, your Personal Information may be collected by any of the following entities (including but not limited to):

- Cigna Life Insurance Company of Europe S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Brussels, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial Services and Markets Authority in the field of consumer protection.
- Cigna Life Insurance Company of Europe S.A.-N.V., UK Branch, a foreign branch of Cigna Life Insurance Company of Europe, S.A. N.V., with corporate address at 5 Aldermanbury Square, 13th Floor, London, England, EC2V 7HR and authorized by the National Bank of Belgium and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority in the UK.
- Cigna Europe Insurance Company S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Belgium, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial

Services and Markets Authority in the field of consumer protection.

- Cigna Europe Insurance Company S.A.-N.V., Brussels, Zurich Branch, a foreign branch of Cigna Europe Insurance Company S.A.-N.V., with corporate address at Europaallee 41, 8004 Zurich, Switzerland, existing under the laws of Switzerland, and registered in the commercial register of Canton Zurich.
- Cigna Global Insurance Company Limited with corporate address in Guernsey at P.O. Box 155, Mill Court, La Charroterie, St Peter Port, Guernsey GY1 4ET 67, and subject to the prudential supervision of the Guernsey Financial Services Commission for the conduct of insurance business.

The company collecting your Personal Information depends on the insurance entity which provides your insurance cover and can be found in your member booklet or certificate of insurance. This company will be the data controller of the Personal Information collected to provide the Services to you.

In addition to this Data Protection Notice, some of our products and services may have their own notices (for example, the [Cigna Online and Mobile Privacy Notice](#), which describes in more detail how your Personal Information is used in a particular context).

PERSONAL INFORMATION

“Personal Information” is the information that identifies and relates to you, or to other individuals which also benefit from our Services, such as your dependents. Your Personal Information may be provided to us by yourself or by a third party entitled to provide us with such information (e.g. your health care providers, your group, etc.).

Due to the nature of the Services you are entitled to, your Personal Information may contain sensitive data including, but not necessarily limited to, your medical condition and health status.

THE TYPES OF PERSONAL INFORMATION WE COLLECT

The Personal Information we collect includes:

- > General information such as your name, address, contact details, date of birth, gender, relationship to the policyholder (where you are not the policyholder);
- > Identification information such as your national identification number, passport number or driving license number;
- > Information linked to the provision of the Services (for example, to review and pay your claims; to issue guarantee of payment/s when applicable);
- > Information about your job including job title or any other that may be strictly required to provide the Services to you, provided that there is a connection between the access to the Services and your job or job title;
- > Information relating to previous policies or claims;
- > Financial information such as your bank or payment details;
- > Telephone recordings and other logs of your correspondence with us; and
- > Sensitive data including details of your current and past physical and/or mental health.

We collect the Personal Information outlined above from a number of different sources, including from:

- > You directly, or from someone else on your behalf (such as a family member that you have formally authorized to do so);
- > Healthcare providers and other medical providers, and other third parties that are required to provide the Services to you (for example loss adjusters, claims handlers, experts (including medical experts));
- > Other third parties involved in the provision of the Services or linked to that provision such as a broker or another insurer, claimants, defendants;
- > Your group (as it may be applicable);

- > Medical reports and counsel opinions;
- > Emergency assistance;
- > Other companies within the Cigna corporate group as may be appropriate to provide the Services to you; and
- > Insurance industry fraud prevention and detection databases and sanctions screening tools.

As we are required to collect your Personal Information as a consequence of a contractual agreement with the group failure to provide this information may prevent or delay the fulfilment of these obligations. For example, if you do not provide certain Personal Information, we will not be able to provide you with the Services.

PURPOSE AND USE OF PERSONAL INFORMATION

Your Personal Information is collected in order to provide the Services, administer your plan and, in general, conduct insurance business in line with the Services you are entitled to. We use your Personal Information to:

- > Provide insurance and assistance services including, for example, claim assessment, processing and settlement; and, where applicable, handle claim disputes;
- > Communicate with you and others, including the group, as part of our Services;
- > Send you important information regarding changes to our policies, other terms and conditions and other administrative information;
- > Make non-automated decisions about whether to provide the Services to you;
- > Provide improved quality, training and security (e.g. with respect to recorded or monitored phone calls to our contact numbers);



- > Continuously improve and test the quality of our Services (for example, conducting satisfaction surveys, research and analysis related to the Services);
- > Protect our business against fraud. This includes searching claims or fraud registers when dealing with insurance requests or claims in order to detect, prevent and investigate fraud;
- > Manage our infrastructure and business operations, and comply with internal policies and procedures, including those relating to auditing; finance and accounting; billing and collections; IT systems; business continuity; and records, document and print management;
- > Resolve complaints and handle requests;
- > Comply with applicable laws and regulatory obligations, including those relating to anti-money laundering and anti-terrorism; and respond to requests from public and governmental authorities and litigation; and
- > Establish and defend legal rights; protect our operations or those of any of our group companies or insurance business partners; safeguard our rights, privacy, safety or property, and/or that of our group companies, you or others; and pursue available remedies or limit our damages.

As outlined above, we may use your Personal Information for a number of different purposes that are always connected with the Services we provide. Consequently, we will rely on the following legal grounds to use your Personal Information:

- > The use of your Personal Information is necessary for the performance of a contract to which you are a party;
- > We have a legal or regulatory obligation to use your Personal Information. For example, we will rely on this ground to comply with anti-money laundering and anti-terrorism obligations; and
- > We have a legitimate interest in using your Personal Information. We may rely on this legal ground for the purpose of providing improved quality, training and managing our infrastructure and operations. When collecting and processing your Personal Information under this ground we put in place robust safeguards to ensure that your privacy is protected and that our legitimate interests are not overridden by your interests or fundamental rights and freedoms.

Due to the nature of the Services you are entitled to, we may process sensitive data connected with the provision of such Services. In general, your consent is not required since we are permitted by applicable law to process such information as a healthcare insurance company. However we may collect your consent in specific situations where either the nature of the data to be disclosed and/or the requirements on the jurisdiction where you are on assignment or other applicable laws and regulations may require that consent.

DISCLOSURE OF YOUR PERSONAL INFORMATION

If necessary for providing you with the Services you are entitled to, or for any of the purposes described in this Data Protection Notice, we may disclose your Personal Information with other parties. Disclosing your Personal Information means that we will provide your Personal Information to and/or that your Personal Information will be accessed by:

- > Cigna group companies. Access to Personal Information within Cigna is restricted to those individuals and entities who have a requirement to access the information for the purposes described in this Data Protection Notice;
- > Other insurance and distribution parties, such as other insurers; reinsurers; brokers and other intermediaries and agents and appointed representatives;
- > Healthcare providers and travel and medical assistance providers;
- > External third-party service providers, such as IT systems, support and hosting service providers; document and records management providers; translators; and similar third-party vendors and outsourced service providers that assist us in carrying out business activities;
- > External professional advisors and partners such as medical professionals, accountants, actuaries, auditors, experts, consultants, lawyers; banks and financial institutions that service our accounts; claim investigators, adjusters and others;
- > Investigative firms we brief to look into claims on our behalf in relation to suspected fraud;
- > Our regulators and other governmental or public authorities where necessary to comply with a legal or regulatory obligation;

> The police and other third parties or law enforcement agencies, court, regulator, government authority or other similar third parties where necessary for the prevention or detection of crime or to comply with a legal or regulatory obligation; or otherwise to protect our rights or the rights of a third party;

> Debt collection & Subrogation agencies;

> Selected third parties in connection with any sale, transfer or disposal of our business;

> Other third parties, such as emergency providers (fire, police and medical emergency services) and travel carriers;

> Your group or a company acting on your group's behalf to monitor, audit or otherwise administer the Services and fulfil contractual obligations in relation to the Services. Consequently, the Personal Information that may be shared will be the minimum necessary to perform the Services you are entitled to. Under no circumstances will Cigna provide any sensitive information (i.e. medical information related to you) to the group without asking for previous express consent from you;

> In addition to the above, we may need to share limited Personal Information with the group in case of an emergency medical evacuation or repatriation ("Emergency") to ensure that your health and safety and the best outcome for you, in case of an Emergency when outside your home country, is achieved. Please be aware that during an Emergency we will try to prevent the immediate and significant effects of illness, injury or conditions which if left untreated would result in a significant deterioration of health and represent a threat to your life. During the complexity of those situations the interaction with your group may be required to provide additional assistance to try to ensure the best possible outcome during an evacuation and/or assess whether to provide other assistance to you out-with the Cigna plan. The Personal Information that may be shared will be the minimum necessary to conduct the evacuation or repatriation in line with the Services you are entitled to. The information that will be shared may be: date of evacuation or repatriation; location where the patient will be evacuated or repatriated from or to; medical conditions which has resulted in the need for the evacuation or repatriation and the medical necessities of the patient during the Emergency. Once you are safely medically repatriated or evacuated that sharing of information will cease immediately; and

> Registers of claims which are shared with other insurers in order to check information to detect and prevent fraudulent claims. The Personal Information put on these registers may include details of injuries.

For any of the categories of the recipients listed above, it should be noted that some of them may be located in the European Economic Area, while others can process and access your Personal Information from outside the European Economic Area, as described in the following section of the Data Protection Notice.

INTERNATIONAL TRANSFER OF PERSONAL INFORMATION OUTSIDE THE EUROPEAN ECONOMIC AREA

Due to the global nature of the Services you are entitled to and the need to provide the group with compliance solutions to meet its needs and ensure that you have access to the Services in the location of your assignment, your Personal Information can be shared with and/or accessed by parties located in other countries outside the European Economic Area that have a different data protection regime than the one found in the country where the group, signing the contract with us, is located. The countries to which we may transfer your Personal Information may not be regarded by the European Commission as ensuring an adequate level of protection for Personal Information (for instance, the United States).

In any case, where we transfer your Personal Information to any of these countries, we will conduct the transfer in accordance with applicable data protection law. This may include ensuring that appropriate safeguards, such as contractual obligations, are put in place with respect to the protection of your Personal Information and your fundamental rights and freedoms, and your rights in relation to your Personal Information. If you would like further information regarding the steps we take to safeguard your Personal Information, or to obtain a copy of the safeguards we put in place to protect it when it is transferred, please contact us using the details in the "Contact Us" section below.

Depending on the country of your assignment or location and the compliance requirements that may apply there you may receive additional privacy notices from us or from our partners.

RETAINING YOUR PERSONAL INFORMATION

We ensure that proper procedures are in place to manage your Personal Information and to remove and/or archive it when necessary.

In general terms, we only retain your Personal Information for as long as is necessary to:

- > Provide you with the Services;
- > Fulfil the purposes outlined in this Data Protection Notice; and
- > Comply with our legal obligations and/or protect our rights.

When your group instructs us to terminate your access to the Services, we will protect your Personal information and will delete it once our retention period to comply with our legal or regulatory obligations and/or protects our rights has lapsed. Our default retention period is 10 years. However, depending on the jurisdiction that governs our contract and the type of information involved, our general retention period may vary between 7 to 10 years.

If you would like further information regarding the periods for which your Personal Information will be stored, please contact us using the details in the “Contact Us” section below.

MARKETING

We may use your Personal Information to provide you with information about our products and services where you have provided your consent for us to do so. In certain circumstances, we may also use your Personal Information to contact you for marketing purposes where we have a legitimate interest to do so, in order to provide you with information about our other products or services which we consider may be of interest to you. If you wish to unsubscribe from emails sent by us, you may do so at any time by clicking on the "unsubscribe" link that appears in all emails. Otherwise you can always contact us using the details set out in the “CONTACT US” section below to update your contact preferences. Please note, however, that we will continue to send you service related (non-marketing) communications.

YOUR RIGHTS

Under data protection law you have certain rights in relation to the Personal Information that we hold about you. You may exercise, as may be applicable, these rights at any time by contacting us using the details set out in the “Contact Us” section below.

Your rights include:

The right to access your Personal Information

You are entitled to a copy of the Personal Information we hold about you and certain details about how we use it. There will not usually be a charge for dealing with these requests.

Your information will usually be provided to you in writing, unless otherwise requested, or where you have made the request by electronic means, in which case the information will be provided to you by electronic means where possible.

The right to rectification

We take reasonable steps to ensure that the Personal Information we hold about you is accurate and complete. However, if you do not believe this is the case, you can ask us to update or amend it.

The right to erasure

In certain circumstances, you have the right to ask us to erase your Personal Information. Please note that in some circumstances exercise of this right will mean we are unable to continue providing you with the Services as outlined above.

The right to object to, and/or to request restriction of processing

In certain circumstances, you are entitled to object to our processing of your Personal Information, or ask us to stop using your Personal Information. Please note that in some circumstances exercise of these rights will mean we are unable to continue providing you with the Services.

The right to data portability

In certain circumstances, you have the right to ask that we provide your Personal Information to you in a commonly used electronic format, and to transfer any Personal Information



that you have provided to us to another third party of your choice.

The right to object to marketing

You can request that we stop sending you marketing messages at any time by clicking on the "unsubscribe" button in any emails that we send to you or by contacting us using the details set out in the "CONTACT US" section of this Data Protection Notice. Please note that even if you exercise this right because you do not want to receive marketing messages, we may still send you service related communications where necessary.

The right not to be subject to automated decision-making (including profiling)

You have a right in some circumstances to not be subject to a decision based solely on automated means, but we do not base our decisions only on automated means.

The right to withdraw consent

As explained previously, we collect and process your Personal Information (including sensitive data) to provide the Services under different grounds, so that is why we do not ask for your consent.

The right to lodge a complaint with a data protection authority

You have a right to complain to your local data protection authority if you believe that any use of your Personal Information by us is in breach of applicable data protection laws and regulations.

Making a complaint will not affect any other legal rights or remedies that you have.

SECURITY

We will take appropriate technical, physical, legal and organizational measures, which are consistent with applicable data protection laws to protect your Personal Information.

CHANGES TO THIS DATA PROTECTION NOTICE

We may update this Data Protection Notice from time to time to ensure that it remains accurate. Please check back each time

that you provide additional Personal Information to us. Where changes to the Notice will have a fundamental impact on the nature of our processing of your Personal Information, or otherwise have a substantial impact on you, we will give you sufficient advance notice so that you have the opportunity to exercise your rights in relation to your Personal Information.

This Data Protection Notice was last updated August 2022.

CONTACT US

Data Protection Officer
Plantin en Moretuslei 309 2140
Antwerp, Belgium
Belgium Email: CGHB-EU-Privacy@cigna.com

CIGNA GLOBAL INSURANCE COMPANY LIMITED

*Address: P.O. Box 155
Mill Court
La Charroterie
St Peter Port Guernsey GY1 4ET*

CIGNA GLOBAL INSURANCE COMPANY LIMITED

POLICYHOLDER: Cigna Global Wellbeing Solutions Limited

PARTICIPATING SPONSOR: Louisiana Tech University

ADDRESS: London, United Kingdom

PARTICIPATING SPONSOR/NUMBER: 10676A

<u>Group Insurance Policy and Policy Number</u>	<u>Effective Date</u>	<u>Anniversary Date</u>
MEDICAL BENEFITS (OPEN ACCESS PLUS)	09/01/2025	09/01
EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS	09/01/2025	09/01

This Policy is issued in Guernsey and shall be governed by its laws.

These Policies contain the terms under which the Insurance Company agrees to insure certain Members and pay benefits.

The Insurance Company and the Participating Sponsor have agreed to all of the terms of these policies.

These materials are being made available electronically for your convenience. Should you have any questions regarding content, please feel free to contact Cigna. A printed document will be provided upon request.



Jennifer Laydon
Financial Analysis Director

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CIGNA GLOBAL INSURANCE COMPANY LIMITED

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the Policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the Certificate to "you" or "yours" refers to the Member.

A Member in any of the classes shown below may be insured but only for the Policy(ies) listed for his Member Class. The Effective Date shown below is the date on which a Policy becomes effective for a Member Class.

A Member will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

GROUP POLICY(IES)		MEMBER CLASS	
<u>Certificate Number</u>	<u>Policy(ies)</u>	<u>Eligible Members</u>	<u>Effective Date</u>
CN001	Medical Benefits (OPEN ACCESS PLUS) Emergency Medical Evacuation And Repatriation Benefits	Students: each member identified as a student by the Participating Group	09/01/2025

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Participating Sponsor and the Insurance Company agree on some other method of premium payment. The Participating Sponsor and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the Policy becomes effective. If the Participating Sponsor and the Insurance Company agree that premiums will be paid on a quarterly, semester, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, by semester, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the Policy will be cancelled except as set forth in the Grace Period.

STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semester, semiannual or annual basis, the Statement Date will be the same number as the Premium Due Date.

PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, by semester, semiannually or annually, a Premium Statement will be prepared as of the Statement Date for the applicable time period. This Statement will reflect any pro rata premium charges and credits due to changes in the number of insured members and changes in insurance amounts that took place in the preceding period.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Statement Date that is the same as or next follows the date that:

- A member becomes insured.
- The amount of insurance on a member changes, but not due to a revision of The Schedule.
- A member ceases to be insured.

PREMIUM RATE FOR MEDICAL EXPENSE INSURANCE. The monthly premium rate for Medical Expense Insurance is determined by written agreement between the Participating Sponsor and Cigna Global Insurance Company Limited.

MEDICAL EXPENSE INSURANCE PREMIUM. The monthly premium for Medical Expense Insurance will be calculated as follows:

- Multiply the number of subscribing Members insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
- Add the results.

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. If daily rates are selected, the Insurance Company calculates by using the monthly rate for each class multiplied by 12, then divided by 365 to produce the daily rate. The daily rate is used to calculate the semester premium, depending on the number of days in each semester. All results are taken to the nearer cent. If the Participating Sponsor and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 60 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by 15% or more.

The Insurance Company may change rates immediately if, following the latter of the effective date or renewal date:

- if the Participating Sponsor fails to provide sufficient information, as required by the Insurance Company to confirm adequacy of premiums currently being paid; or
- any reinsurance obtained by the Insurance Company in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by 15% or more, or the Insurance Company's retention increases by 15% or more.

As of any Anniversary Date after the Policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this Policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the Participating Sponsor or its Members.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in governing law or by a revision in the insurance under the Policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

PREMIUM EXCLUSIVE OF INDIRECT TAXES. All fees charged by the Insurance Company are exclusive of any applicable indirect taxes which are the liability of the Participating Sponsor including but not limited to value-added tax, goods and services tax, sales or use tax, or other similar taxes. If Insurance Company determines it is required to collect and remit any such taxes on the Participating Sponsor's behalf, Insurance Company will include such charges in the manner and at the rate prescribed by law.

Experience for Pooled Coverage under this Policy may be combined with the experience for coverage which is deemed pooled under other group insurance policies providing similar insurance issued by the Insurance Company.

POOLED COVERAGE. Pooled Coverage means any Medical Benefits paid for a member in a policy year while this coverage is in force after a certain level of benefits have already been paid in that year for him.

CHANGE IN WAR RISK COVERAGE PREMIUM

The premium, the benefits, and the territorial area for the War Risk coverage provided thereby (or any one or more of them) may be revised by agreement between the Insurance Company and the Participating Sponsor at any time, to reflect a change in the war risk exposure.

CANCELLATION OF POLICY

The Participating Sponsor may cancel the Policy as of any Premium Due Date by giving written notice to the Insurance Company before the date.

In the event the Participating Sponsor cancels the Policy on a Premium Due Date which is other than the Policy Anniversary Date, the Insurance Company will return the unearned portion of premium paid.

The Insurance Company may cancel the Policy due to the following reasons only:

- with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable governing law;
- as of any Premium Due Date, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;
- as to a Participating Sponsor to which this Policy is issued, immediately, if the Participating Sponsor has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;
- as of any Premium Due Date, if the number of insured Members fails to meet the minimum required per Participating Sponsor participation rules; or for failure to comply with any other material plan provision relating to Participating Sponsor contributions or Participating Sponsor participation rules;
- if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable governing law;
- in accordance with any applicable governing law, if it is determined that the size of the Participating Sponsor has changed, making such Participating Sponsor eligible for a guaranteed issued small group product;
- in accordance with any applicable governing law, if prior notice is given to the Participating Sponsor;
- as to a Participating Sponsor member of an association to which this Policy is issued, when the Participating Sponsor's membership in the association ceases, in accordance with applicable governing law.

In the event of termination by the Insurance Company, the Insurance Company shall compute the earned premium and promptly return the unearned portion of premium paid. Premium adjustment may be made either at the time termination is effective or as soon as practical after termination becomes effective, but payment or tender of unearned premium is not a condition of termination.

In the event of termination of war risk coverage the earned premium will be computed.

Notwithstanding anything to the contrary in the Policy, either the Participating Sponsor or the Insurance Company may terminate War Risk coverage upon written notice to the other. Termination by the Participating Sponsor shall become effective upon receipt of such written notice mailed to or delivered to the Insurance Company's Home Office, or on a later date if specified in such notice. Termination by the Company shall become effective upon the date specified by us in such written notice mailed or delivered to the Participating Sponsor at the last address shown in the Insurance Company's records. In no event shall it become effective in less than ten (10) days after such notice is mailed or delivered.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this Policy may be modified to reflect product revisions which have been uniformly made to this product.

PARTICIPATING PLAN SPONSOR GRACE PERIOD. If, before a Premium Due Date, the Participating Sponsor has not given written notice to the Insurance Company that the Policy is to be canceled, a Grace Period of 90 days will be granted for

the payment of each premium attributable to the membership after the initial premium. The Policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the Policy will automatically be canceled at the end of the Grace Period; except that, if the Participating Sponsor has given written notice in advance of an earlier date of cancellation, the Policy will be canceled as of the earlier date. The Participating Sponsor will be liable to the Insurance Company for any unpaid premium for the time the Policy was in force.

MEMBER GRACE PERIOD. Members will not have a grace period for premium payment under this policy. Eligibility terms require adherence to the method of premium payment agreed to by the Participating Plan Sponsor and the Insurance Company. Payment must be made by the member in accordance to the policy in order to be enrolled in the benefit coverage.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The Policy is executed at the Home Office of the Insurance Company. The address of the Insurance Company is:

St Martin's House
Le Bordage
St Peter Port, Guernsey GY 14AU.

COMPLIANCE. The Insurance Company's products and services may not be available in all jurisdictions and are expressly excluded from this Policy where prohibited by applicable law.

SANCTIONS: It is the Insurance Company's Policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. The Insurance Company will not offer coverage or pay benefits to or on behalf of any member if doing so would violate these sanctions rules. In the event the Insurance Company learns that a sanctioned individual or entity is enrolled under this Policy, or that a Participating Sponsor becomes sanctioned, the Insurance Company will take all appropriate action, which could include blocking, reporting, and terminating coverage. The Insurance Company is under no obligation to notify the member or Participating Sponsor in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions rules.

In addition, restrictions will apply to claims incurred in sanctioned countries in the absence of an approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, the Insurance Company will not cover: (1) elective or pre-scheduled treatment in sanctioned countries; or (2) members considered "ordinarily resident" in a sanctioned country. A member is considered "ordinarily resident" if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.

CONSIDERATION. The Policy is issued to the Participating Sponsor in consideration of payment of premiums.

INSURANCE DATA. The Participating Sponsor will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Participating Sponsor to give this data will not void or continue a Member's insurance. The Insurance Company has the right to examine the Participating Sponsor's records relative to these benefits at any reasonable time while the Policy is in effect. It also has this right until all rights and obligations under the Policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

COMPLAINTS. Any complaint should in the first instance be sent to the Insurance Company at:

Cigna
Attn: Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

If the complaint is not resolved to your satisfaction, you may raise the complaint to the Channel Islands Financial Ombudsman Service at:

The Channel Islands Financial Ombudsman (CIFO)
P.O. Box 114
Jersey, Channel Islands
JE4 9QG
Telephone: +44 (0)1534 748610
Fax: +44 (0)1534 747629
Email: enquiries@ci-fo.org
Website www.ci-fo.org

ADDITIONAL PROGRAMS. The Insurance Company may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Members for the purpose of promoting their general health and well-being. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Participating Sponsor. Contact the Insurance Company for details of these programs.

We do not provide tax advice. Consult your financial or tax adviser for information about appropriate tax treatment of benefit payments and reimbursements.

INCONTESTABILITY. The validity of the Policy shall not be contested after it has been in force for two years from the Policy Effective Date except for non-payment of premium. No statement made by any member covered under the Policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such member's lifetime nor unless it is contained in a written instrument signed by him or her; provided however, that no such provision shall preclude the assertion at any time of defenses based upon the member's ineligibility for coverage under the Policy or upon other provisions in the Policy.

OTHER PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the Policy, the application of the Participating Sponsor, a copy of which is attached to the Policy and all subsequent versions of the Policy, and the applications, if any, of the Members.

POLICY CHANGES. Changes may be made in the Policy only by amendment signed by the Participating Sponsor and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the Policy.

STATEMENTS NOT WARRANTIES. All statements made by the Participating Sponsor or by an insured Member will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Participating Sponsor or by the Member to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Participating Sponsor or the Member and a copy is sent to the Participating Sponsor, the Member or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Participating Sponsor for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within one year (365 days) after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within one year (365 days) after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any member for whom claim is pending as often as it may reasonably require.

RIGHT TO KNOW: The Participating Sponsor has the right to obtain information about how the plan operates the care delivery system and an explanation of the benefits to which participants are entitled under the terms of the plan. Additional information regarding the plan may be obtained by contacting the Participating Sponsor's sales office.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the Policy until at least 90 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the Policy.

TIME LIMITATIONS. If any time limit set forth in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the locale in which the Member lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

CERTIFICATES. The Insurance Company will issue to the Participating Sponsor for delivery to each insured Member an individual Certificate. The Participating Sponsor will be responsible for distributing the Certificates to its Members. The Certificate will show the benefits provided under the Policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the Certificate will change or void the terms of the Policy.

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Member or Dependent must be given to the Insurance Company within (90) days of the loss of eligibility. Upon receipt of such notice, the Insurance Company will assess whether the Member or Dependent incurred a claim on or after the requested termination date, and if so, the Insurance Company will process the termination of eligibility to be effective after the most recent date of service unless otherwise agreed by the Insurance Company in writing. If written notice of the termination of eligibility of any Member or Dependent is not received by the Insurance Company within (90) days of the date of loss of eligibility for an

Member or Dependent, then the Participating Sponsor shall be responsible for all claims for that Member or Dependent incurred after the requested termination date.

RIGHT TO AUDIT. The Insurance Company reserves the right to audit the Participating Sponsor's billing records and premium accounting practices. If we discover:

- an underpayment of premium by the Participating Sponsor—, the Participating Sponsor will be obligated to pay the underpayment amount, in a timely manner; or
- an overpayment of premium, we will return any overpayment amount in a timely manner.

CLERICAL ERROR. Clerical error or delays in making entries on the records by the Insurance Company or its designees will not void this Policy or any covered member's insurance if it would otherwise have been in effect. Such clerical error will not cause any member to become insured if such member was not otherwise eligible. Such clerical error will also not extend any covered member's coverage if such coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

MULTIPLE INTERNATIONAL COVERAGES. The Participating Sponsor certifies that the covered members are only covered under one international expatriate Policy offered by the Insurance Company. The Participating Sponsor certifies that a covered member cannot have coverage under another international expatriate Policy offered by the Insurance Company.

NON-COMPLIANCE WITH POLICY REQUIREMENTS. Any express or implied waiver by the Insurance Company of any requirements of this Policy is not a continuing waiver of such requirements. Any failure by the Insurance Company to enforce any Policy provision will not be a waiver or amendment of that provision.

CIGNA GLOBAL INSURANCE COMPANY LIMITED
PO Box 155 Mill Court
La Charroterie
St. Peter Port, Guernsey GY1 4ET

GROUP POLICY

POLICYHOLDER: CIGNA GLOBAL WELLBEING SOLUTIONS

PARTICIPATING SPONSOR/GROUP: Louisiana Tech University

POLICY NUMBER: 10676A

POLICY EFFECTIVE DATE: September 1, 2025

POLICY ANNIVERSARY DATE: September 1

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

These materials are being made available electronically for your convenience. Should you have any questions regarding content, please feel free to contact Cigna. A printed document will be provided upon request.

By:

A handwritten signature in black ink, appearing to read "Jae Lay", with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

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SCHEDULE OF BENEFITS

Premium Due Date: The 1st day of each calendar month.

Classes of Eligible Members

Students: Each member identified as a student by the Participating Group.

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SCHEDULE OF BENEFITS

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Member must be in Active Service/Enrollment to be eligible for coverage. It will be extended by the number of days the Member is not in Active Service/Enrollment.

For Members eligible on or before the Policy Effective Date:	A period of time as determined by the Group

For Members eligible after the Policy Effective Date:	A period of time as determined by the Group

ACCIDENT INSURANCE BENEFITS

Member Benefits

Amount of Insurance	\$10,000

Age Based Reductions	Accident Insurance Benefits for a Member age 65 or older are payable as follows:
	Age 65-69 65% of Accident Insurance Benefits
	Age 70 and over 50% of Accident Insurance Benefits

ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

MEMBER

A member in one of the Classes of Eligible Members shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the Eligibility Waiting Period, if later.

Except as noted in the Reinstatement Provision, if a Member terminates coverage and later wishes to reapply, or if a former Member is rehired, a new Eligibility Waiting Period must be satisfied. A Member is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Members, but continues to be employed by the Participating Group, and within one year becomes a member of an eligible class.

EFFECTIVE DATE OF INSURANCE

A Member will be insured on the date he or she becomes eligible, if the Member is not required to contribute to the cost of this insurance.

If an eligible Member is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

TERMINATION OF INSURANCE

Coverage will end on the earliest of the following dates:

1. the date the Member is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date a Member is no longer in Active Service;
6. for a Member, the date the Participating Group cancels participation under the Policy.
7. the date the Member's medical insurance policy is terminated.

CONTINUATION OF INSURANCE

If a Member is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

ACCIDENT INSURANCE BENEFITS

The Insurance Company will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses, if a Member is insured under the Policy for Accident Insurance on the date of an Accident. If more than one loss results from the same Accident, the Insurance Company will pay only the largest Benefit Amount to which the Insured is entitled.

The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

Schedule of Losses	Benefit Amount
Life, or Two Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

ACCIDENT INSURANCE EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).
2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
4. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, or a similar air transport service of another country; an aircraft owned or leased by or for the Participating Group, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.
5. Injuries arising out of, or in the course of, any work for wage or profit.
6. Commission of a felony.
7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.
8. Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in St. Peter Port, Guernsey or to our agent. Notice should include the Participating Group's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Participating Group is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Participating Group if not permitted by applicable privacy laws.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

CLAIM PROVISIONS

(Continued)

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to \$1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary

The Insured may change the beneficiary at any time by giving written notice to the Participating Group or the Insurance Company. The beneficiary's consent is not required for this or any other change which the Insured may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Participating Group or the Insurance Company. When this form is received, it will take effect as of the date of the form. If the Insured dies before the form is received, the Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

CLAIM PROVISIONS

(Continued)

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the locale in which the Member lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

Physician/Patient Relationship

The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Relationship to Medical Insurance

This Policy is a rider to the medical insurance policy issued to the Policyholder by the Insurance Company. This Policy is valid only during such period as the medical insurance policy is in effect.

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or provincial law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Participating Group has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

ADMINISTRATIVE PROVISIONS

(Continued)

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Premium Exclusive of Indirect Taxes

All fees charged by the Insurance Company are exclusive of any applicable indirect taxes which are the liability of the Policyholder, including but not limited to value-added tax, goods and services tax, sales or use tax, or other similar taxes. If Insurance Company determines it is required to collect and remit any such taxes on the Policyholder's behalf, Insurance Company will include such charges in the manner and at the rate prescribed by law.

Reporting Requirements

The Participating Group must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium

The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Participating Group and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation

The Participating Group or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A Policy Grace Period of 90 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Participating Group is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Reinstatement of Insurance

Coverage may be reinstated without satisfying the Insurability Requirement, if a Member's insurance ends because he or she is on an unpaid leave of absence or has disenrolled from School and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

ADMINISTRATIVE PROVISIONS
(Continued)

APPEAL AND COMPLAINTS

Any claim appeal or complaint should in the first instance be sent to the Insurance Company at:

Cigna
Attn: Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

If the complaint is not resolved to your satisfaction, you may raise the complaint to the Channel Islands Financial Ombudsman Service at:

The Channel Islands Financial Ombudsman (CIFO)
P.O. Box 114
Jersey, Channel Islands
JE4 9QG
Telephone: +44 (0)1534 748610
Fax: +44 (0)1534 747629
Email: enquiries@ci-fo.org
Website www.ci-fo.org

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR MEMBER BENEFITS

Basic Accident Insurance

Rate included in the Medical Premium

GENERAL POLICY PROVISIONS

Entire Contract

The entire contract will be made up of the Policy, the application of the Participating Group, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability

All statements made by the Participating Group or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy. After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes

No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates

A certificate of insurance will be delivered to the Policyholder for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

GENERAL POLICY PROVISIONS

(Continued)

Male Pronoun

The male Pronoun as used herein will be deemed to include the female.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency

The Participating Group and Plan Administrator are agents of the Member for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

Compliance

The Insurance Company's products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service/Enrollment

If you are a Member, you are in Active Service / Enrollment with the Participating Group on the day you become actively enrolled as an international student studying outside your home country of permanent resident.

Injury

Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurance Company

The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured

A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Member

For eligibility purposes, you are a member if the following conditions are met.

1. You are actively enrolled as an international student studying abroad outside of your home country of permanent residence
2. You actively work for the Participating Group and are in one of the "Classes of Eligible Members."
3. You are member of the Participating Group who is insured under the Policy.

Participating Group

The term Participating Group means an educational institution participating in the Trust to which this policy is issued.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Member, a Member's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of a Member or spouse, or a person living in an Member's household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Participating Group in effect directly prior to the Policy Effective Date.

Sickness

Any physical or mental illness.

**GROUP AD&D
INSURANCE CERTIFICATE**

**Participating Sponsor/Group:
LOUISIANA TECH UNIVERSITY**

FOREWORD

AD&D insurance provides individuals and their families with financial protection. The AD&D Insurance Benefit described in this booklet will help secure your family's financial security in the event of your accident.

The need for accident insurance protection depends on individual circumstances and financial situations. This valuable coverage should add an extra dimension to your personal insurance portfolio.

In an effort to make your benefit program more comprehensive and responsive to your needs, your Participating Group is providing this insurance to you at no cost.

CIGNA GLOBAL INSURANCE COMPANY LIMITED

PO Box 155 Mill Court

La Charroterie

St. Peter Port, Guernsey GY1 4ET

**GROUP INSURANCE
CERTIFICATE**

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your Participating Group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your Participating Group or Cigna.

A handwritten signature in black ink, appearing to read "Jae Lay", with a stylized flourish at the end.

Jennifer Laydon
Financial Analysis Director

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SCHEDULE OF BENEFITS

Policy Effective Date: September 1, 2025

Policy Anniversary Date: September 1

Policy Number: 10676A

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active Members of the Participating Group.

Your Eligibility Waiting Period

If applicable, the Eligibility Waiting Period is the period of time you must wait to be eligible for coverage as determined by the Participating Group.

ACCIDENT INSURANCE BENEFITS

Member Benefits

Amount of Insurance \$10,000

Age Based Reductions

If you are age 65 or older, your Accident Insurance Benefits are payable as follows:

Age 65 to 69	65% of Accident Insurance Benefits
Age 70 and over	50% of Accident Insurance Benefits

WHO IS ELIGIBLE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law or sanctions rules will not be considered eligible under this plan.

MEMBER

A Member in one of the Classes of Eligible Members shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the Eligibility Waiting Period if applicable, if later.

Except as noted in the Reinstatement Provision, if a Member terminates coverage and later wishes to reapply, or if a former Member is rehired/reenrolled, a new Eligibility Waiting Period must be satisfied. A Member is not required to satisfy a new Eligibility Waiting Period, if insurance ends because he or she is no longer in a Class of Eligible Members, but continues to be employed by the Participating Group, and within one year becomes a member of an eligible class.

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are not in Active Service/Enrollment on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for a Member, the date the Participating Group cancels participation under the Policy; and
7. the date your medical insurance policy is terminated.

ACCIDENT INSURANCE BENEFITS

If you are a Member and insured under the Policy for Accident Insurance on the date of an Accident, we will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses. If more than one loss results from the same Accident, we will pay only the largest Benefit Amount to which you are entitled. The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

Schedule of Losses	Benefit Amount
Life, or Two Members	100%
One Member	50%
Thumb and Index Finger of the Same Hand.....	25%

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

WHAT IS NOT COVERED

ACCIDENT EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).
2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)
3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)
4. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, or a similar air transport service of another country; an aircraft owned or leased by or for the Participating Group, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.
5. Injuries arising out of, or in the course of, any work for wage or profit.
6. Commission of a felony.
7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured's country of citizenship.
8. Covered Services to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in St. Peter Port, Guernsey or to our agent. Notice should include the Participating Group's name, the Policy Number and the claimant's name and address.

Claim Forms

When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Participating Group is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Participating Group in these areas is confidential and may not be used or released by the Participating Group if not permitted by applicable privacy laws.

Proof of Loss

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

CLAIM PROVISIONS

(Continued)

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Change of Beneficiary

You may change your beneficiary at any time by giving written notice to the Participating Group or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Participating Group or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

CLAIM PROVISIONS

(Continued)

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the locale in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that locale.

Physician/Patient Relationship

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Reinstatement of Insurance

Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Service.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.

1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

GENERAL PROVISIONS

Incontestability

All statements made by the Participating Group or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age

If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits

We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

GENERAL PROVISIONS
(Continued)

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Active Service/Enrollment

If you are a Member, you are in Active Service / Enrollment with the Participating Group on the day you become actively enrolled as an international student studying outside your home country of permanent resident.

Injury

Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

Insurance Company

The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Member

For eligibility purposes, you are a member if the following conditions are met.

1. You are actively enrolled as an international student studying abroad outside of your home country of permanent residence
2. You actively work for the Participating Group and are in one of the "Classes of Eligible Members."
3. You are member of the Participating Group who is insured under the Policy.

Participating Group

The term Participating Group means an educational institution participating in the Trust to which this policy is issued.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Participating Group and in effect directly prior to the Policy Effective Date.

Sickness

The term Sickness means a physical or mental illness.

Appeal Procedure for Denied Claims

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

When You Have an Appeal or Complaint

If you have questions, disagree with the determination of a claim, or have a complaint, you may contact Cigna at the address indicated below. A written request for a claim review must be sent in writing to:

Cigna
Attn: Appeals & Complaints
P.O. Box 15800
Wilmington, DE 19850 USA

For a claim review, you should state the reason(s) why you feel your claim should have been approved. Send a copy of the denial along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. For questions, please contact the Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).

It is important to include your Name, Group Number, Member/Patient ID Number, Name of the patient and relationship, and "Attention: Appeals" on all supporting documents. You are entitled to receive free upon request access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the final decision in a timely manner, as described in your plan materials.

Appeal Procedure for Denied Claims (Continued)

If you are still not satisfied with our final decision to your complaint or appeal, you can refer your complaint or appeal to the Channel Islands Financial Ombudsman Service at the address below:

The Channel Islands Financial Ombudsman (CIFO)

PO Box 114

Jersey, Channel Islands

JE4 9QG

Telephone: +44 (0)1534 748610

Fax: +44 (0)1534 747629

Email: enquiries@ci-fo.org

Website www.ci-fo.org

UNDERWRITTEN BY:
CIGNA GLOBAL INSURANCE COMPANY LIMITED
a Cigna company

11/2025



GROUP INBOUND TRAVEL INSURANCE POLICY

POLICYHOLDER: Fairmont Specialty Trust

POLICYHOLDER ADDRESS: ITA Global Trust, LTD
Suite 4210, 2nd Floor Canella Court,
48 Market St,
Camana Bay
PO Box 32203,
Grand Cayman KY1-1208,
Cayman Islands

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: August 29, 2023

EXPIRATION DATE: August 28, 2024

UMR: B115R180022

The Policy is a legal contract between the Policyholder and Crum & Forster SPC for and on behalf of ITI SP (herein referenced as “the Company”).

This Policy is issued by Crum & Forster SPC for and on behalf of ITI SP to the Fairmont Specialty Trust located in the Cayman Islands.

This Policy is not subject to U.S. jurisdiction.

The Company agrees to provide insurance, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in the Policy.

The Company and the Policyholder have agreed to all the terms and conditions of the Policy. The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

THIS IS LIMITED BENEFIT SHORT DURATION COVERAGE.

READ IT CAREFULLY.

THE POLICY IS NOT RENEWABLE.

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The following provisions appear within the Policy in the following order:

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SCHEDULE OF BENEFITS

POLICYHOLDER: FAIRMONT SPECIALTY TRUST

PARTICIPATING ORGANIZATION: Louisiana Tech University

EFFECTIVE DATE: 8/01/2023

POLICY NUMBER: CC008744

UMR: B115R180022

PREMIUM DUE DATE: Monthly in advance on the 1st of each month

POLICY PERIOD: August 29, 2023 through August 28, 2024

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class. Also, a person may not be covered as a Dependent and a Plan Participant at the same time.

Class 1: Non-United States Citizens traveling outside their Home Country having his or her true, fixed and permanent home and principal establishment outside of the United States, and who holds a current and valid passport.

Class 2: Spouses of the above eligible Class, who is considered to be a covered Class and whose Application has been accepted by the Company.

Natural or legally adopted Dependent unmarried children of an above eligible Class under 18 years of age who is considered to be a covered Class and whose Application has been accepted by the Company.

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum: \$10,000

Class 2 Principal Sum: \$5,000 Spouse / \$1,000 Child

Time Period for Loss: 365 days

Loss of:

Benefit:

(Percentage of Principal Sum)

Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

Benefits will be provided only for the Coverages listed below and will be paid only up to the amounts shown.

Policy Term Maximum for all Injury and Sickness Medical Expenses:	\$250,000
Deductible Per Plan Participant Per Policy Term:	\$200
Deductible at Student Health Center:	\$0
Initial Treatment Period:	90 Days from the date of Injury or Sickness
Out-of-Pocket Maximum Per Plan Participant Per Policy Term:	\$5,000
Coinsurance:	Network Provider: 100% of the Preferred Allowance (PA) Non-Network Provider: 80% of Usual, Reasonable & Customary (URC) Charges
Terms of Payment	Full Excess

Any Deductibles, Coinsurance, Co-payments, Benefit Periods, and Benefit Maximums apply on a per Plan Participant basis.

After the Deductible has been satisfied, benefits will be paid as listed below for the Provider selected.

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Hospital Room & Board Benefit	100% of PA, subject to a \$50 copay per admission	80% of URC
Intensive Care/Cardiac Care Unit Benefit	100% of PA	80% of URC
Hospital Miscellaneous Expense Benefit	100% of PA	80% of URC

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Surgeon (In or Outpatient) Benefits	100% of PA	80% of URC
Assistant Surgeon Benefit	100% of PA	80% of URC
Pre-Admission Testing Benefit	100% of PA	80% of URC
Anesthesia Benefit	100% of PA	80% of URC
Day Surgery Miscellaneous Benefit	100% of PA	80% of URC
Diagnostic X-Ray and Lab Benefit	100% of PA	80% of URC
Ambulance Benefit	100% of PA	80% of URC
Physician Visit Benefit (Inpatient)	100% of PA	80% of URC
Physician Visit Benefit (Outpatient)	100% of PA, subject to a \$25 copay	80% of URC
Consultant Physician Benefit	100% of PA, subject to a \$25 copay	80% of URC
Radiation/Chemotherapy Benefit	100% of PA	80% of URC
Emergency Room Benefit	100% of PA, subject to a \$150 copay <i>(waived if admitted)</i>	80% of URC
Extension of Accident and Sickness Medical Benefits	100% of PA	80% of URC
Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness	Covered as any other Sickness

BENEFIT COVERAGE	BENEFIT AMOUNT	
	In-Network Provider Benefit	Out-of-Network Provider Benefit
Wellness Medical Benefit (<i>Up to \$250 per policy term</i>)	100% of PA	80% of URC
MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT AND ALCOHOL & DRUG ABUSE EXPENSE BENEFIT		
In-Patient Expense	100% of PA	80% of URC
Out-Patient Expense	100% of PA, subject to \$25 copay for Physician Office Visits	80% of URC
Emergency Dental Expense Benefit	100% of PA	80% of URC
Physiotherapy Expense Benefit - Inpatient	100% of PA	80% of URC
Physiotherapy Expense Benefit - Outpatient	100% of PA, subject to a \$25 copay per visit	80% of URC
Durable Medical Equipment Expense Benefit	100% of PA	80% of URC
Emergency Medical Evacuation Expense Benefit	100% of actual expense up to \$100,000	
Emergency Medical Repatriation Expense Benefit	Student - 100% of actual expense up to \$25,000 Spouse & Child: 100% of actual expense up to \$50,000	
PRESCRIPTION DRUG EXPENSE BENEFIT	Wellfleet Rx/ESI Network Provider	Non-Network Provider:
Covered Percentage:	75% of the Preferred Allowance based on a 30-day supply per prescription	Not Covered
Contraceptive Drugs	Based on Above	Not Covered

NOTES:

- We do not pay benefits for the amount of Eligible Expenses paid by You as Your Coinsurance or

Co-pay amount.

- **Eligible Expenses** will be paid under the Inpatient benefits for Surgery and under the Outpatient benefits for Surgery, but not both for the same or related procedure.

DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Policy the capitalized terms used herein are defined as follows:

Additional terms may be defined within the provision to which they apply.

Accident means an unforeseeable event which:

- 1) Causes Injury to one or more Plan Participants; and
- 2) Occurs while coverage is in effect for the Plan Participant.

AIDS means Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Benefit Period means the period of time from the date of the Accident causing the Injury or Sickness for which benefits are payable, as shown in the Schedule of Benefits, and the date after which no further benefits will be paid.

Caregiver means an individual employed for the purpose of providing assistance with activities of daily living to the Plan Participant or to the Plan Participant's Immediate Family Member who has a physical or mental impairment. The Caregiver must be employed by the Plan Participant or the Plan Participant's Immediate Family Member. A Caregiver is not a babysitter; childcare service, facility or provider; or persons employed by any service, provider or facility to supply assisted living or skilled nursing personnel.

Child means the Plan Participant's natural Child, adopted Child (or Child placed in the Plan Participant's home for purposes of adoption), foster Child, stepchild, or other Child for whom the Plan Participant has legal guardianship (proof will be required). A Child must reside with the Plan Participant in a parent-Child relationship. NOTE: In the event the Plan Participant shares physical custody of the Child with another parent, the requirement that the Child reside with the Plan Participant will be waived.

Child Caregiver means an individual providing basic childcare service needs for the Plan Participant's minor children under the age of 18 while the Plan Participant is on the Trip without the minor children. The arrangement of being the Child Caregiver while the Plan Participant is on the Trip must be made 30 or more days prior to the Scheduled Departure Date.

Civil Union Partner means a party to a civil union who is entitled to the same legal obligations, responsibilities, protections and benefits that are afforded a spouse. Throughout the Policy, a party to a civil union shall be included in any definition or use of the terms such as spouse, Immediate Family, dependent, next of kin, and other terms descriptive of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon. The term spouse or dependent includes civil union couples whenever used.

Class means a group of people defined by a common characteristic, including but not limited to demographic group and geographic region.

Coinsurance means the percentage of Eligible Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means Crum & Forster SPC for and on behalf of ITI SP. Also hereinafter referred to as We, Us and Our.

Complications of Pregnancy means a condition which:

- When pregnancy is not terminated, requires medical treatment and whose diagnosis is distinct from pregnancy but is adversely affected by or are caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; and (i) other similar medical and surgical conditions of comparable severity related to pregnancy.
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;

Complications of Pregnancy will not include:

- False Labor;
- Occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- Morning Sickness; and
- Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a complication of pregnancy if the cesarean section is *non-elective*. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the Child or mother.

Contraceptive Drugs include oral contraceptives (combined estrogen and progestin and progestin-only), NuvaRing, Depo Vera and Ortho Evra.

Co-Payment means a specified charge that the Plan Participant is required to pay when a medical service is rendered.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Plan Participant and results in a Covered Loss for which benefits are payable.

Covered Loss or Covered Losses means an accidental death, dismemberment, Sickness or other Injury covered under the Policy and indicated on the Schedule of Benefits.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Plan Participant, whether or not totally disabled, in the activities of daily living.

Deductible means the dollar amount of Eligible Expenses which must be incurred and paid by the Plan Participant before benefits are payable under the Policy. It applies separately to each Plan Participant.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Dependent means a Plan Participant's:

- 1) lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Union Partner.
- 2) unmarried Children under age 18.

The age limitations will not apply to a Plan Participant's unmarried Child who is dependent on the Plan Participant or other care providers for lifetime care and supervision, and incapable of self-sustaining

employment by reason of mental or physical handicap that occurred before age 18. Proof of such dependence and incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

Domestic Partner means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Plan Participant and shared financial assets/obligations with the Plan Participant. Both the Plan Participant and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Plan Participant nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Elective Treatment and Procedures means any Medical Treatment or surgical procedure that is not medically necessary, including any service, treatment, or supplies that are deemed by the federal, or a state or local government authority, or by the Company to be research or experimental or that is not recognized as a generally accepted medical practice.

Eligible Expenses means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Plan Participant for the Medically Necessary treatment of an Injury or Sickness. Eligible Expenses must be incurred while the Policy is in force.

Emergency/Emergency Treatment means a Sickness or Injury for which the Plan Participant seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn Child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Experimental/Investigational means that a drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable Evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Management staff in Our Claims Department or a Claims Payor acting on Our behalf will make the determination if the drug, device or medical care is Experimental/Investigational based on the above criteria.

Expatriate means (1) a person working or living outside their country of citizenship; (2) a person working outside their country of citizenship and outside the employer's country of domicile; or (3) non-U.S. citizens working in the United States.

Extended Care Facility means an institution operating pursuant to applicable laws that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and Registered Nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

He, His and Him includes "she", "her" and "hers."

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- 1) Group or blanket insurance, whether on an insured or self-funded basis;
- 2) Hospital or medical service organizations on a group basis;
- 3) Health Maintenance Organizations on a group basis.
- 4) Group labor management plans;
- 5) Employee benefit organization plan;
- 6) Professional association plans on a group basis; or
- 7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- 8) Automobile no-fault coverage (unless prohibited by law).

Home Country means the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, holds a current and valid passport, and to which he or she has the intention of returning.

Home Health Care means nursing care, treatment and Daily Living Services provided in the Plan Participant's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care; and Necessary care and treatment are not available from a Plan Participant's Immediate Family Member or other persons residing with the Plan Participant without causing undue hardship;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

Home Health Care consists of, but shall not be limited to, the following:

- Part time and intermittent skilled nursing services: services given to the Plan Participant at least once every 60 days or as frequently as a few hours per day, several days per week.
- Therapeutic services: physical therapy occupational therapy; speech and hearing therapy; and
- Medical social services, medical supplies, drugs and medicines, related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the Evidence of Coverage if the Plan Participant had remained in the Hospital.

Host Country means any country other than the country where a Plan Participant has his or her true, fixed and permanent home and principal establishment, and holds a current and valid passport.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons;
- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by registered nurses (R.N.) on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a) on its premises; or
 - b) in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Eligible Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Immediate Family means a Plan Participant's spouse, domestic partner, civil union partner, parent (includes Step-parent), Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws). A Member of the Immediate Family includes an individual who normally lives in the Plan Participant's household.

Immunizations Include: flu shot, tetanus, diphtheria, pertussis, Tdap, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, meningococcal; only as recommended by the U.S. Centers for Disease Control and Prevention.

Injury means bodily harm which results independently of disease or bodily infirmity, from an Accident after the effective date of a Plan Participant's coverage under the Policy, while the Policy is in force as

to the person whose Injury is the basis of the claim. All injuries to the same Plan Participant sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient means a Plan Participant who is confined in an institution and is charged for room and board.

Insurance means the coverage that is provided under the Policy.

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

Intoxicated means a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Plan Participant is located at the time of an incident.

Master Application means the Application for the Master Policy.

Maximum Benefit means the largest total amount of Eligible Expenses that the Company will pay for the Plan Participant as shown in the Plan Participant's Schedule of Benefits.

Medically Necessary means a treatment, drug, device, service, procedure or supply that is:

- 1) Required, necessary and appropriate for the diagnosis or treatment of a Sickness or Injury;
- 2) Prescribed or ordered by a Physician or furnished by a Hospital;
- 3) Performed in the least costly setting required by the condition;
- 4) Consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

The purchasing or renting air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Eligible Expense.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided for education purposes or the convenience of the Plan Participant, the Plan Participant's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- It can be safely provided to the patient on a less cost effective basis such as out-patient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the

medical care or treatment is rendered to a Plan Participant.

Mountaineering means the sport, hobby, or profession of walking, hiking, and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Natural Teeth means the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one Occurrence without regard to the period of time or the area over which such losses occur.

Outpatient means a Plan Participant who receives care in a Hospital or another institution, including; ambulatory surgical center; convalescent/skilled nursing facility; or Physician's office, for a Sickness or Injury, but who is not confined and is not charged for room and board.

Outpatient Surgical Facility means a surgical or medical center which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate Registered Nurses; (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

Out-of-Pocket Maximum means the maximum dollar amount the Plan Participant is responsible to pay during a Policy Term. After the Plan Participant has reached the Out-of-Pocket Maximum, the Policy pays 100% of Eligible Expenses for the remainder of the Policy Term. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Co-payments. Penalties and amounts above the Usual, Reasonable and Customary Expenses do not count toward the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is shown on the Schedule of Benefits.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Participating Organization means any organization which elects to offer coverage by completing a Participation Agreement and that has been approved by the Company to sponsor coverage under the Policy.

Participation Agreement means the agreement completed by a Participating Organization for insurance under the Master Policy.

Permanent Residence means the country where an Plan Participant has his or her true, fixed and permanent home and principal establishment, and to which he or she has the intention of returning.

Physician means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Plan Participant, a Plan Participant's Spouse, son, daughter, father, mother, brother or sister or other relative.

Physical Therapy means any form of the following administered by a Physician: (1) physical or mechanical therapy; (2) diathermy, (3) ultra-sonic therapy; (4) heat treatment in any form; or (5) manipulation or massage.

Plan Participant means a Person and Dependent eligible for coverage as identified in the Enrollment/Application who is a Non-United States Citizen traveling outside their Home Country, has his or her true, fixed and permanent home and principal establishment outside of the United States, holds a current and valid passport, and for whom proper premium payment has been made when due, and who is therefore a Plan Participant under the Policy.

Policy means this document, the Master Application of the Policyholder and the Participating Organization and any end endorsements, riders or amendments that will attach during the Period of Coverage.

Policy Period means the period of time following the Policy's Effective Date, as shown on the Schedule of Benefits.

Policyholder means the entity shown as the Policyholder in the Schedule of Benefits.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Eligible Expenses.

Pre-Existing Condition means an Injury, Sickness, disease, or other condition during the 6-month period immediately prior to the date the Plan Participant's coverage is effective for which the Plan Participant: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 6-month period before coverage is effective under the Plan Participant's Plan.

Pregnancy means the physical condition of being pregnant, including Complication of Pregnancy.

Prescription Drugs means drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration.

Registered Nurse means a licensed registered professional Registered Nurse (R.N.).

Rehabilitation Facility means a non-residential facility that provides therapy and training rehabilitation services at a single location in a coordinated fashion, by or under the supervision of a physician pursuant to the law of the jurisdiction in which treatment is provided. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. The facility may be either of the following:

- 1) A Hospital or a special unit of a Hospital designated as a Rehabilitation Facility; or
- 2) A free standing facility.

Service Provider means a Hospital, convalescent/skilled nursing facility, ambulatory surgical center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, birthing center, Physician, Dentist, chiropractor, licensed medical practitioner, Registered Nurse, medical laboratory, assistance service company, air/ground ambulance firm, or any other such facility that the Company approves.

Sickness means illness or disease which requires treatment by a Physician while covered by this Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven days a week, under the supervision of a Registered Nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Spouse means lawful spouse, if not legally separated or divorced, Domestic Partner, or Civil Partner.

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

Surgery or Surgical Procedure means an invasive diagnostic procedure; or the treatment of Sickness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Usual, Reasonable and Customary means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

- The actual amount charged by the provider;

- The negotiated rate; or
- The charge which would have been made by the provider (Physician, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by Us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Usual, Reasonable and Customary Charges, Fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

We, Our, Us means Crum & Forster SPC for and on behalf of ITI SP.

You, Your, Yours, He or She means the Plan Participant who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

Persons eligible to be a Plan Participant under the Policy are those persons described as an ELIGIBLE CLASS on the Schedule of Benefits. This includes anyone who may become eligible while the Policy is in force.

We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

A Plan Participant Person's Dependent(s), as applicable, are eligible on the latest of the date:

- 1) the Plan Participant is eligible, if the Plan Participant has Dependents on that date; or
- 2) the date the person becomes a Dependent; or
- 3) the next Annual Open Enrollment (if applicable) following the date the person becomes a Dependent if the Newborn Children Coverage, Newborn Adopted Children Coverage or Adopted Children Coverage provisions do not apply.

If the Plan Participant is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under the Policy. In no event will a Dependent be eligible if the Plan Participant is not eligible.

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.

EFFECTIVE DATES OF INSURANCE

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder and will continue in force until either a) the Policy Expiration Date stated in the Schedule; or b) the Policy is cancelled pursuant to the terms of the Policy.

Plan Participant's Effective Date for Coverage:

A Person will become a Plan Participant under the Policy, provided proper premium payment is made, on the latest of:

- 1) The Effective Date of the Policy; or
- 2) The date the Company receives a completed application or enrollment form; or
- 3) The day the Plan Participant becomes eligible, subject to any required waiting period, according to the referenced date requested and shown in the Application/Enrollment Form; or
- 4) The moment the Plan Participant departs their Home Country airspace; or
- 5) The Date the Company approves the Application; or
- 6) The Date requested by the Participating Organization.

Newborn Children Coverage: Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31 day period.

Adopted Children Coverage: Coverage for an adopted Child, other than a newborn, will begin from the date of placement in Your home for the purpose of adoption or the date of an entry of an interim court order granting You temporary custody of the child, whichever comes first. A notice of placement for adoption must be submitted to Us. If notice is not given within 31 days, coverage for the adopted Child will terminate upon the expiration of the initial 31-day period.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

- 1) The Policy Expiration Date shown in the Policy; or
- 2) The premium due date if premiums are not paid when due, subject to any grace period.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date by giving written notice to the other and the Participating Organization at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

Termination Date of the Participating Organization. Coverage for a Participating Organization will terminate on the earliest of the following dates:

- 1) The date the Participating Organization no longer meets the definition of a Participating Organization;
- 2) The date the Participating Organization loses its entity by means of dissolution, merger, or otherwise;
- 3) The date the Participating Organization is eliminated as a Participating Organization by an amendment to or change in the Policy;
- 4) The date ending the Coverage Month for which the last premium payment is made for the Participating Organization's insurance;
- 5) The last day of a Coverage Month, provided the Company has given the Participating Organization at least 30-calendar days prior written notice; and
- 6) The last day of a Coverage Month, if the Participating Organization has given the Company at least 30-calendar days prior written notice.

Termination of the Policy, or termination of coverage for a Participating Organization, under any conditions will be without prejudice to any claim incurred prior to termination.

Plan Participant's Termination Date for Coverage:

Insurance for a Plan Participant will end on the earliest of:

- 1) The date the Plan Participant is no longer in an Eligible Class; or
- 2) The date the Plan Participant returns to his or her Home Country; or
- 3) The expiration of 364 days from the Effective Date of Coverage; or
- 4) The date shown on the Evidence of Coverage issued by the Company; or
- 5) The date the Plan Participant becomes a permanent resident of the United States; or
- 6) The date the Plan Participant reports for full-time active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
 - a) The date the premium is fully earned; or
 - b) The Expiration Date of the Policy.

This does not include Reserve or National Guard duty for training;

- 7) The end of the period for which the last premium contribution is made; or
- 8) The date the Policy is terminated; or
- 9) The date the Plan Participant requests, in writing, that his/her coverage be terminated; or
- 10) The date the Plan Participant's participation in the Program terminates; or
- 11) The date the Plan Participant's Trip is completed; or
- 12) The date the Participating Organization is no longer eligible to sponsor coverage under the Policy; or
- 13) The expiration date of the term of coverage, requested by the Participating Organization; or
- 14) The end of the Benefit Period shown in the Schedule of Benefits.

Dependent's Termination Date

A Dependent's coverage under the Policy ends on the earliest of:

- 1) The date the Policy terminates; or
- 2) The date the Plan Participant's coverage ends; or

- 3) The date the Dependent is no longer a Dependent; or
- 4) The last day of the period for which premiums have been paid
- 5) The end of the Benefit Period shown in the Schedule of Benefits.

PREMIUM PROVISIONS

Premiums:

The Company provides insurance in return for premium payments. The premium shown in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium due dates are the first of every month unless otherwise stated in the Policy. Premium payment made in advance or for more than a one month period will not affect any provisions of the Policy with regard to change. Premiums due for the Policy will be remitted to Us by an officer of the Policyholder or by any other person designated by the Policyholder to remit such premiums. Premium is due at the time of enrollment.

Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

The Company has the right to rely upon the accuracy of the Participating Organization's calculations and to require the Participating Organization to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Participating Organization will pay the additional premium or apply the premium credit at the next premium due date.

Grace Period:

A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period provided the Participating Organization pays all of the premiums due by the last day of the grace period, unless notice has been sent, in accordance with the TERMINATION provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. Notice will be sent to the Participating Organization's most recent address in Our records.

No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in the factors bearing on the risk assumed.
- 4) A misrepresentation in the information relied on in establishing the rate for the Policy
- 5) A change in the experience rating.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Reinstatement

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Participating Organization submits written application to the Company, the Company accepts the application and the Participating Organization makes payment of all overdue premiums.

SCOPE OF COVERAGE

Benefits are payable under the Policy for Eligible Expenses incurred by a Plan Participant for the items stated in the, Schedule of Benefits. Benefits will be payable to either the Plan Participant or the Service Provider for Eligible Expenses incurred outside of the Plan Participant's Home Country.

The charges enumerated herein will in no event include any amount of such charges which are in excess of Usual, Reasonable and Customary charges. If the charge incurred is in excess of such average charge such excess amount will not be recognized as a Eligible Expense. All charges will be deemed to be incurred on the date such services or supplies, which give rise to the expense or charge, are rendered or obtained.

We will provide the benefits described in the Policy to all Plan Participants who suffer a Covered Loss which:

- 1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS**; and
- 2) Occurs while the person is a Plan Participant under the Policy.

Terms of Payment for Benefits:

Full Excess Medical Expense:

If an Injury or Sickness to the Plan Participant results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, We will pay the Eligible Expenses incurred, subject to any applicable Deductible Amount, Benefit Period, Co-Payment, and Coinsurance Percentage, that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Plan Participant must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury or Sickness:

- 1) While the person is a Plan Participant under the Policy; or
- 2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under the Policy is shown on the SCHEDULE OF BENEFITS and is subject to the specific maximums shown on the SCHEDULE OF BENEFITS.

DESCRIPTION OF BENEFITS

PART A: ACCIDENT AND SICKNESS BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 Principal Sum:	\$10,000
Class 2 Principal Sum:	\$10,000
Time Period for Loss:	365 days

Loss of:

Loss of Life
Loss of Both Hands
Loss of Both Feet

Benefit:

(Percentage of Principal Sum)

100%
100%
100%

Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT and SICKNESS MEDICAL EXPENSE BENEFITS

We will pay Accident or Injury and Sickness Medical Expense Benefits for Eligible Expenses. These benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident or Injury and Sickness Medical Expense Benefits are only payable:

- 1) for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Eligible Expenses incurred by or on behalf of the Plan Participant;
- 3) for Eligible Expenses incurred within 30 days after the date of the Eligible Expense.

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

- 1) **Hospital Admission Expenses:** Charges for each hospital admission.
- 2) **Outpatient Pre-Surgical Testing benefit** – charges for Pre-surgical testing. A scheduled surgical procedure must occur within 7 days of the testing.
- 3) **Nursing Services** – Outpatient Charges for nursing services by a Registered Nurse or Licensed Professional.
- 4) **Skilled Nursing Facility** - charges for services as described in the schedule of benefits. The benefit provides skilled nursing 24 hours a day, seven days a week, under the supervision of a registered nurse, and/or skilled rehabilitative services at least five days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A SNF provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence.

A SNF confinement must take place within 14 days from a hospital discharge and must represent care for the same condition which required hospitalization that lasted a minimum of three days. Care may not be custodial in nature (e.g., care which could be performed at home). The facility may not be primarily a place which provides general care for the aged.
- 5) Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- 6) Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.

ADDITIONAL BENEFITS

HOSPITAL ROOM & BOARD BENEFIT

We will pay charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

INTENSIVE CARE / CARDIAC CARE UNIT BENEFIT

We will pay charges for each day of Intensive Care /Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

HOSPITAL MISCELLANEOUS EXPENSE BENEFIT

We will pay for services, supplies and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

SURGEON (IN OR OUTPATIENT) BENEFITS

We will pay charges for:

- 1) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.
- 2) A Physician, for assistant surgeon duties up to the Maximum Benefit shown in the Schedule of Benefits.

ASSISTANT SURGEON BENEFIT

If, in connection with such operation, a Plan Participant requires the services of an Assistant Surgeon, We will pay the Covered Percentage of the Covered Expense incurred.

PRE-ADMISSION TESTING BENEFIT

We will pay benefits for charges for Pre-admission testing (inpatient confinement must occur within 7 days of the testing).

ANESTHESIA BENEFIT

We will pay benefits for Anesthesia for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

DAY SURGERY MISCELLANEOUS BENEFIT

We will pay Day Surgery Miscellaneous benefits for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an outpatient basis.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

We will pay the benefit if the Plan Participant requires diagnostic x-ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Injury or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

AMBULANCE BENEFIT

When, by reason of Injury or Sickness, a Plan Participant requires the use of a community or Hospital Ambulance in a Medical Emergency, We will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Plan Participant is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness or if the Plan Participant is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered a Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

PHYSICIAN VISIT BENEFIT (INPATIENT)

We will pay charges by a Physician for other than pre- or post-operative care for in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.

PHYSICIAN VISIT BENEFIT (OUTPATIENT)

We will pay charges by a Physician for office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

CONSULTANT PHYSICIAN BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Eligible expenses incurred.

RADIATION/ CHEMOTHERAPY THERAPY EXPENSE BENEFIT

We will pay the Covered Percentage for the Eligible expenses incurred by a Plan Participant for drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as:

- 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm;
- 2) the drug is approved by the FDA for use in antineoplastic therapy;
- 3) the drug is used as part of an antineoplastic drug regimen;
- 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and
- 5) the Physician has obtained informed consent from the patient for the treatment regimen that includes FDA approved drugs for off-label indications.

EMERGENCY ROOM BENEFIT

We will pay this benefit if the Plan Participant requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Injury or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people Emergency Treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

If a Student seeks treatment at the Student Health Center and treatment is not possible at the Student Health Center and a student is referred to the ER, co-payments for the Emergency Room will be half of the scheduled amount.

EXTENSION OF ACCIDENT AND SICKNESS MEDICAL BENEFITS

If a Plan Participant is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy benefits will continue to be paid for that condition for a period of up to 30 days, or the maximum benefit has been paid, whichever occurs first.

MATERNITY AND PRE-NATAL CARE BENEFIT

When a covered Maternity is incurred by a Plan Participant the Company will pay the Usual, Reasonable and Customary medical expenses in excess of the Deductible and Coinsurance as stated in the Schedule of Benefits, Maternity. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits Maternity, as to Eligible Expenses during any one period of individual coverage.

Benefits will be payable for Eligible Expenses an Plan Participant incurs before, during, and after delivery of a Child, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Plan Participant and her newborn Child in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Plan Participant Person's attending Physician determines further Inpatient postpartum care is not necessary for the Plan Participant or her newborn Child provided the following are met:

- 1) In the opinion of the Plan Participant Person's attending Physician, the newborn Child meets the criteria for medical stability in the guidelines for Perinatal Care prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
 - a) The antepartum, intrapartum, postpartum course of the mother and infant;
 - b) The gestational stage, birth weight, and clinical condition of the infant;
 - c) The demonstrated ability of the mother to care for the infant after discharge; and
 - d) The availability of post discharge follow up to verify the condition of the infant after discharge; and
2. One (1) at-home post-delivery care visit is provided to the Plan Participant at her residence by a Physician or Registered Nurse performed no later than forty-eight (48) hours following discharge of the Plan Participant and her newborn Child from the Hospital. Coverage for this visit includes, but is not limited to:
 - a) Parent education;
 - b) Assistance in training in breast or bottle feeding; and
 - c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Plan Participant or newborn Child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Plan Participant Person's discretion, this visit may occur at the Physician's office.)

WELLNESS MEDICAL EXPENSE BENEFIT

We will pay Eligible Expenses, as per the limits stated in the Schedule of Benefits, Sickness Medical. Coverage is limited to the following expenses incurred subject to Exclusions. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include:

1. Routine physical examinations: per Plan term which includes, one routine physical examination, laboratory tests, x-rays and any other medical expense related to the examination.

2. Preventive medical attention: includes, annual Screening Mammogram for women; an annual cervical screening for women; a gynecological exam for women; Immunizations; Contraceptive Devices; Colorectal screening for adults over 50, an annual standard prostate diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors.

MENTAL AND NERVOUS CONDITIONS EXPENSE BENEFIT

If a Plan Participant requires treatment for a Mental or Nervous Condition, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant requires Hospital Confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT MENTAL AND NERVOUS SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the outpatient treatment of Mental and Nervous Conditions as defined up to one visit per day.

The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary.

Outpatient treatment and Physician services include charges made by an outpatient treatment department of a Hospital, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness.

We will pay the Covered Percentage of the Eligible Expenses incurred for treatment of biologically based mental Sickness, including:

- a) Schizophrenia;
- b) Schizoaffective disorder;
- c) bipolar affective disorder;
- d) major depressive disorder;
- e) specific obsessive-compulsive disorder;
- f) delusional disorders;
- g) obsessive compulsive disorders;
- h) binge eating, anorexia and bulimia; and

- i) panic disorder.

ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If a Plan Participant requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When a Plan Participant is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay the Covered Percentage of the Eligible Expenses incurred for such Hospital Confinement.

Such Confinement must be in a licensed or certified facility, including Hospitals.

BENEFITS FOR OUTPATIENT ALCOHOL and DRUG SERVICES

We will pay the Covered Percentage of the Eligible Expenses incurred for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Physician services include charges for services rendered in a Physician's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Physician or a licensed psychologist who certifies that a Plan Participant needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by:

- a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
- b) managing withdrawal symptoms; and
- c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

EMERGENCY DENTAL EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to sustaining an Injury to natural teeth.

PHYSIOTHERAPY EXPENSE BENEFIT

We will pay benefits as described in the Schedule of Benefits for eligible Physiotherapy expenses incurred by the Plan Participant. We will pay Usual, Reasonable and Customary expenses in excess of the

Deductible as stated in the Schedule of Benefits. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to Eligible Expenses during any one period of individual coverage.

For the purpose of this section, **Physiotherapy means** charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement or following hospitalization and administered by a licensed physiotherapist, up to up to the maximum amount shown in the Schedule of Benefits per day for the Physiotherapy benefit.

Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, microtherm, chiropractic, adjustments, manipulation, acupuncture, massage or any form of physical therapy.

DURABLE MEDICAL EQUIPMENT EXPENSE BENEFIT

If, by reason of Injury or Sickness, a Plan Participant requires the use of Durable Medical Equipment, We will pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for such Durable Medical Equipment. We pay the Covered Percentage of the Eligible Expenses incurred by a Plan Participant for the purchase or rental of such item. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. If Durable Medical Equipment is purchased, it is Our property and is to be returned to Us, at Our expense, upon completion of a Plan Participant's need, if so requested by Us.

We do not pay for the replacement of Durable Medical Equipment.

Durable Medical Equipment which includes braces and appliances means medical equipment that:

- 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
- 2) can withstand long-term repeated use without replacement;
- 3) is not useful in the absence of an Injury or Sickness; and
- 4) can be used in the home without medical supervision.

EMERGENCY MEDICAL EVACUATION, MEDICAL REPATRIATION AND RETURN OF REMAINS

When You suffer loss of life for any reason or incur a Sickness or Injury during the course of Your Trip, the following benefits are payable, up to the Maximum Benefit Amount shown in the Schedule of Benefits.

- 1) **Emergency Medical Evacuation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment.
- 2) **Medical Repatriation:** If the local attending Legally Qualified Physician and the authorized travel assistance company determine that it is Medically Necessary for You to return to Your primary place of residence because of an unforeseen Sickness or Injury which is acute or life-threatening, the Transportation Expense incurred within 30 days from the date of the Covered Loss, will be paid for Your return to Your primary place of residence or to a Hospital or medical facility closest to Your

primary place of residence capable of providing continued treatment via one of the following methods of transportation, as approved, in writing, by the authorized travel assistance company:

- a) one-way Economy Transportation;
 - b) commercial air upgrade (to Business or First Class), based on Your condition as recommended by the local attending Legally Qualified Physician and verified in writing [and considered necessary by the authorized travel assistance company; or
 - c) other covered land or air transportation including, but not limited to, commercial stretcher, medical escort, or the Usual and Customary Charges for air ambulance, provided such transportation has been pre-approved and arranged by the authorized travel assistance company. Transportation must be via the most direct and economical route.
- 3) Return of Remains: In the event of Your death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and transportation of Your remains to Your primary place of residence in the United States of America or to the place of burial.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount, co-payment, and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:

- 1) Under Federal law may only be dispensed by written prescription; and
- 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the outpatient use by the Plan Participant:

- 1) On or after the Plan Participant's Effective Date; and
- 2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

EXCLUSIONS

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

- 1) War or any act of war, declared or undeclared;
- 2) Any Covered Loss which occurs while the Plan Participant is on Active Duty Service in any Armed Forces, National Guard, military, naval or air service or organized reserve corps;
- 3) Any Covered Loss sustained while in the service of the armed forces of any country. When the Plan Participant enters the armed forces of any country, We will refund the unearned pro rata premium upon request;
- 4) Voluntary, active participation in a riot or insurrection;
- 5) Medical Treatment related to organ transplants, whether as donor or recipient; this includes expenses incurred for the evaluation process, the transplant surgery, post-operative treatment, and

expenses incurred in obtaining, storing or transporting a donor organ. In relation to a bone marrow or stem cell transplant this exclusion would include harvesting & mobilization charges;

- 6) Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal occupation;
- 7) Eligible Expenses for which the Plan Participant would not be responsible in the absence of the Policy;
- 8) Charges which are in excess of Usual, Reasonable and Customary charges;
- 9) Charges that are not Medically Necessary;
- 10) Charges provided at no cost to the Plan Participant;
- 11) Expenses incurred for treatment while in Your Home Country;
- 12) Expenses incurred for an Accident or Injury or Sickness after the Benefit Period shown in the Schedule of Benefits or incurred after the termination date of coverage;
- 13) Services or treatment rendered by a Physician, Registered Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Plan Participant;
- 14) Duplicate services actually provided by both a certified nurse midwife and Physician;
- 15) Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
- 16) Drug, treatment or procedure that either promotes conception, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 17) Charges incurred for Surgery or treatments which are, Experimental/Investigational, or for research purposes;
- 18) Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Plan Participant is covered under the Policy, and rendered within 6 months of the Accident;
- 19) Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
- 20) Weak, strained or flat feet, corns, calluses, or toenails;
- 21) Private-duty nursing services;
- 22) Expenses payable under any prior policy which was in force for the person making the claim;
- 23) Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 24) Pre-existing conditions; however a Pre-Existing condition will be covered after the Plan Participant has been continuously insured for 6 months under the same Participating Organization;
- 25) Injury sustained while taking part in: mountaineering; hang gliding; parachuting; bungee jumping; racing by horse, motor vehicle or motorcycle; motorcycle riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; solo diving; snorkeling; snow skiing; spelunking; parasailing; white water rafting; surfing and snow boarding.
- 26) Practice or play in any intercollegiate, professional or semiprofessional sports contest or competition;
- 27) Rest cures or custodial care;
- 28) Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness);

- 29) Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
- a) While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Plan Participant or any member of his household; or
 - e) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
 - f) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
- Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private aircraft used for business or pleasure purposes.
- 30) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly.
- 31) Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction.

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice of death, or Injury or Sickness must be given to Us within 30 days after a Covered Loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized licensed agent. Notice should include the Policyholder's name and number and a Plan Participant's name and address.

If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30-day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS:

When We receive the notice of claim, We will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, the Proof of Loss requirements stated below will be deemed to have been met by submitting, within the time required under PROOF OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS:

Written proof of loss must be furnished to Us in the case of a claim for loss for which the Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90-day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIMELY FILING OF CLAIMS:

All claims for benefits under the Policy must be submitted to Us no more than 90 days from the date of service or date of death.

TIME OF PAYMENT OF CLAIMS:

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid within 30 days after Our receipt of due written proof of such loss.

Subject to written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid within 30 days after Our receipt of a written proof of loss, unless otherwise stated in the Description of Benefits.

Failure to pay claims within 30 days shall entitle the claimant to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. A claimant or their assignee shall be notified by Us of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

PAYMENT OF CLAIMS:

All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy.

All other benefits will be paid to the Plan Participant suffering the loss. If the Plan Participant dies before all payments due have been made, the amount still payable will be paid to His/Her beneficiary as described in the Designation and Change of Beneficiary provision of the Policy.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

Any other accrued benefits which are unpaid at a Plan Participant's death may, at Our option, be paid either to His beneficiary or to His estate. All other benefits, unless specifically stated otherwise, will be paid to a Plan Participant.

DESIGNATION OR CHANGE OF BENEFICIARY:

Each Plan Participant may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order:

- 1) Beneficiaries designated in writing by the Plan Participant for the Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Plan Participant's lawful spouse, if not legally separated or divorced, Domestic Partner or Civil Union Partner;
 - b) a Plan Participant's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Plan Participant has or had legal guardianship (proof will be required); or
 - c) a Plan Participant's parents, whether natural, step or adoptive; or
 - d) a Plan Participant's Sisters or Brothers, otherwise.
- 4) The estate of the Plan Participant.

A Plan Participant may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Plan Participant is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Plan Participant. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Plan Participant's estate.

PHYSICAL EXAMINATION AND AUTOPSY:

We have the right to have a Physician of Our choice examine the Plan Participant as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT:

If benefits are overpaid, or paid in error We have the right to recover the amount overpaid or paid in error by any of the following methods.

- 1) A request for lump sum payment of the amount overpaid or paid in error or
- 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Plan Participant any benefits We have paid to him for injuries:

- (1) Received in a covered Accident; and

(2) Which are covered under:

- (a) workers' compensation or similar statutory remedies available under law; or
- b) Any employer's liability Insurance.

It will be assumed that the Plan Participant is in receipt of such benefits unless he gives us proof such benefits have been denied to him.

“Recovery” means monies paid to the Plan Participant through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

RIGHT OF REIMBURSEMENT / SUBROGATION:

If a Plan Participant recovers expenses for Sickness or Injury that occurred due to the negligence of a third party, We have the right to reimbursement for all benefits We paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Plan Participant, the Plan Participant's parents if the Plan Participant is a minor, or the Plan Participant's legal representative as a result of that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability.

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

LEGAL ACTIONS:

No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

COMPLAINTS

In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at [\[Administrator/Producer contact information.\]](#)

Data Protection

Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:

The Policy, the application of the Policyholder, a copy of which is attached, endorsements, riders, and the application or participation agreement with the Participating Organization and attached papers constitute the entire contract between the parties. If an application of a Plan Participant is required, the application of any Plan Participant, at Our option, may also be made a part of this contract.

All statements made by the Policyholder, Participating Organization, or by a Plan Participant are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of his death or incapacity, his beneficiary or representative. After 2-years from the Plan Participant's effective date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

No change in the Policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE:

The Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

RECORDS MAINTAINED:

The Policyholder or its authorized administrator will maintain records of the essential features of each Plan Participant's insurance under the Policy.

We shall be permitted to examine the Policyholder's records relating to coverage under the Policy. Examination may occur at any reasonable time up to the later of:

- (1) The two year period after the expiration of the Policyholder's coverage; or
- (2) The final adjustment and settlement of all claims under the Policyholder's coverage.

REPORTING REQUIREMENTS:

The Policyholder or its authorized agent must report to us, by the premium due date:

- (1) The names of all Plan Participants on the Effective Date of the Policy;
- (2) The names of all persons who are Plan Participant after the Effective Date of the Policy;
- (3) The names of those persons whose insurance has terminated; and
- (4) Additional information required as agreed to by Us and the Policyholder.

EVIDENCE OF COVERAGE:

An Evidence of Coverage of insurance will be delivered to the Participating Organization for delivery to each Plan Participant. Each Evidence of Coverage will list the benefits, conditions and limits of the Evidence of Coverage. It will state to whom the benefits will be paid.

POLICY TERMINATION:

We may terminate coverage on or after the anniversary of any premium due date. The Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

OTHER COVERAGE WITH US:

At any one time each Plan Participant may have only one Evidence of Coverage issued by Us having coverage similar to that described in the Policy. If we find He has more than one such Evidence of Coverage, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other Evidence of Coverages for concurrent periods of coverage.

CLERICAL ERROR:

Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

ASSIGNMENT:

No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

INSOLVENCY:

The insolvency, Bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Plan Participants under the Policy.

WAIVER:

Failure of the Company to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

Addendum #1 - Attachment #11

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

Top 10 Diagnosis Categories by Number of Claims – Tabular

LOUISIANA TECH UNIVERSITY-IB

Policy Year: 2020-21

Paid Date: through 05/31/2021



Relation™

Version 5

Policy Year	ICD Category	# Claims	# Charges	\$ Paid	% Paid
2020-21	External Causes of Morbidity	89	0	\$7,098	19.89%
	UnSpecified	52	0	\$8,734	24.47%
	Symptoms, Signs and Abnormal Clinical and Laboratory Findings	33	0	\$4,354	12.20%
	Diseases of the Musculoskeletal System and Connective Tissue	18	0	\$3,064	8.58%
	Diseases of the Genitourinary Systems	13	0	\$1,820	5.10%
	Diseases of the Respiratory System	13	0	\$1,196	3.35%
	Injury, Poisoning and Certain Other Consequences of External Causes	13	0	\$3,412	9.56%
	Endocrine, Nutritional and Metabolic Diseases	11	0	\$695	1.95%
	Diseases of the Eye and Adnexa	7	0	\$1,184	3.32%
	Diseases of the Skin and Subcutaneous Tissue	7	0	\$450	1.26%
	All other ICD Categories	23	0	\$3,681	10.31%
	Total	279	0	\$35,689	100 %

Data Source: HTH

Executed by: Relation Execution time: 6/17/2021 7:24:48 PM

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Top 5 Claims



Showing top 5 claims by \$ Paid

ICD	\$ Paid
(UnSpec) UnSpecified	\$1,743
(873.42) Open wnd forehead w/o ment	\$1,416
(UnSpec) UnSpecified	\$1,257
(719.46) Pain in joint, lower leg	\$1,093
(136.21) Specific infection due to	\$1,066
All Other Claims	\$30,445
Total	\$37,019

Top 5 Benefits



Showing top 5 benefits by \$ Paid

Benefits	\$ Paid
(M1B) Office visits - established	\$7,007
(T1H) Lab tests - other	\$6,134
(M1A) Office visits - new	\$5,327
(M3) Emergency room visit	\$2,084
(O1G) Immunizations/Vaccinations	\$1,959
All Other Benefits	\$14,509
Total	\$37,019

Data Source: HTH

Executed by: Relation Execution time: 7/9/2021 12:59:12 PM

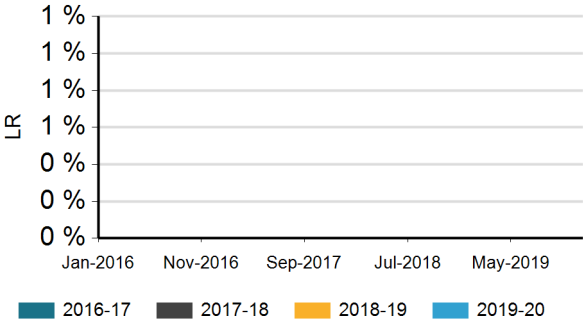
This information has been provided by Relation Insurance Services to aid in understanding of policy experience and should not be used for comprehensive or predictive analysis, which can be requested via your account team. Additionally, this information may only be viewed by active policy administrators per HIPAA compliance and guidelines that protect patient health information.

School Group Losses

Policy Year	\$ Premium	\$ Paid	% LR
2020-21	\$281,310	\$37,019	13.2%

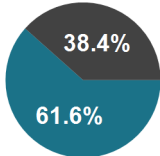
Loss Ratio Trend

Showing loss ratio trend for up to 4 most recent policy years where available (Inclusive of all fees and bulk billing)



Network Status

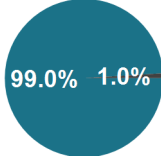
(by \$Paid)



In Out

Claim Type

(by \$Paid)



Medical RX

Claims by Member Type

Year	Insured	Enrollees	Utilizers	# Claims	\$ Paid
2020-21	Subscriber	255	123	274	\$33,404
	Spouse/DP	5	2	5	\$1,213
	Child	1	2	12	\$2,403

Term Enrollment

Term	Student	Sp/DP	Child	Total
Fall-2	223	3	1	227
Spring	206	2	1	209
Summer	134	0	1	135
Winter- Plan B	204	0	1	205
Total	767	5	4	776

Paid Claims by Paid Month

LOUISIANA TECH UNIVERSITY-IB

Policy Year: 2020-21

Paid Date: through 05/31/2021



Month of Payment	# Claims	# Charges	\$ Incurred	\$ Excluded	\$ PPO Disc	\$ Other Ins	\$ Deductible	\$ Copay	\$ Coins	\$ Paid	% Paid
October 2020	33	0	\$0	\$1,003	\$0	\$0	\$2,197	\$907	\$39	\$2,070	5.80%
November 2020	37	0	\$0	\$433	\$0	\$0	\$1,760	\$1,041	\$8	\$5,088	14.26%
December 2020	61	0	\$0	\$16,284	\$0	\$0	\$1,732	\$1,275	\$0	\$5,293	14.83%
January 2021	80	0	\$0	\$9,618	\$0	\$0	\$616	\$538	\$14	\$9,575	26.83%
February 2021	40	0	\$0	\$4,287	\$0	\$0	\$1,230	\$838	\$0	\$1,660	4.65%
March 2021	35	0	\$0	\$3,307	\$0	\$0	\$391	\$1,279	\$0	\$2,569	7.20%
April 2021	68	0	\$0	\$2,718	\$0	\$0	\$646	\$758	\$9	\$4,836	13.55%
May 2021	56	0	\$0	\$1,129	\$0	\$0	\$833	\$715	\$14	\$4,599	12.89%
Totals		0	\$0	\$38,780	\$0	\$0	\$9,405	\$7,351	\$83	\$35,689	

Data Source: HTH

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Addendum #1 - Attachment #12

Bid Number: 50012-563-26	Bid Title: International Student Health Insurance

Standard School Report	Enrollment Dashboard	Claims Dashboard	Medical Cost Per Member	Medical Cost Comparison	HighDollar Claimants	Top Provider	Diagnosis	Loss Ratio Dashboard	Rx Reporting
School Name LOUISIANA TECH UNIV	Plan Year All	Report Type Life to Date	Provider All	Utilization Metric All	NetworkStatus All		All	Division All	Age Bracket

LOUISIANA TECH UNIV					
		Paid Claims Amount		% of Total Paid	
		2023	2024	2023	2024
	Unclassified	\$23,767	\$16,875	5.23%	3.21%
	Rx	\$5,131	\$46,056	1.13%	8.75%
A00 - B99	Infectious and parasitic diseases	\$3,136	\$9,700	0.69%	1.84%
C00 - D49	Neoplasms	\$483	\$99	0.11%	0.02%
D50 - D89	Blood and immune diseases	\$346	\$1,997	0.08%	0.38%
E00 - E90	Endocrine, nutritional and metabolic diseases	\$1,882	\$16,282	0.41%	3.09%
F01 - F99	Mental and behavioral disorders	\$107,520	\$2,331	23.65%	0.44%
G00 - G99	Diseases of the nervous system	\$1,013	\$14,889	0.22%	2.83%
H00 - H59	Diseases of the eye and adnexa	\$31,197	\$4,737	6.86%	0.90%
H60 - H95	Diseases of the ear and mastoid process	\$1,332	\$1,207	0.29%	0.23%
I00 - I99	Diseases of the circulatory system	\$4,340	\$6,768	0.95%	1.29%
J00 - J99	Diseases of the respiratory system	\$6,143	\$7,262	1.35%	1.38%
K00 - K99	Diseases of the digestive system	\$134,666	\$13,370	29.62%	2.54%
L00 - L99	Diseases of the skin and subcutaneous tissue	\$1,763	\$13,667	0.39%	2.60%
M00 - M99	Diseases of the musculoskeletal system and ...	\$3,530	\$17,359	0.78%	3.30%
N00 - N99	Diseases of the genitourinary system	\$1,345	\$13,611	0.30%	2.59%
O00 - O9A	Pregnancy, childbirth and the puerperium	\$36,445	\$18,592	8.02%	3.53%
P00 - P96	Certain conditions originating in the perinatal ...	\$198	\$2,236	0.04%	0.42%
Q00 - Q99	Congenital malformations, deformations and ...	\$0	\$0	0.00%	0.00%
R00 - R99	Symptoms, signs and abnormal clinical and l...	\$59,243	\$84,496	13.03%	16.06%
S00 - T98	Injury, poisoning and certain other consequ...	\$4,605	\$122,669	1.01%	23.31%
V00 - Y99	External causes of morbidity	\$0	\$1,091	0.00%	0.21%
Z00 - Z99	Factors influencing health status and contact...	\$26,554	\$110,975	5.84%	21.09%
Grand Total		\$454,637	\$526,269	100.00%	100.00%

Based on policy respective start dates, paid through 4/30/2026
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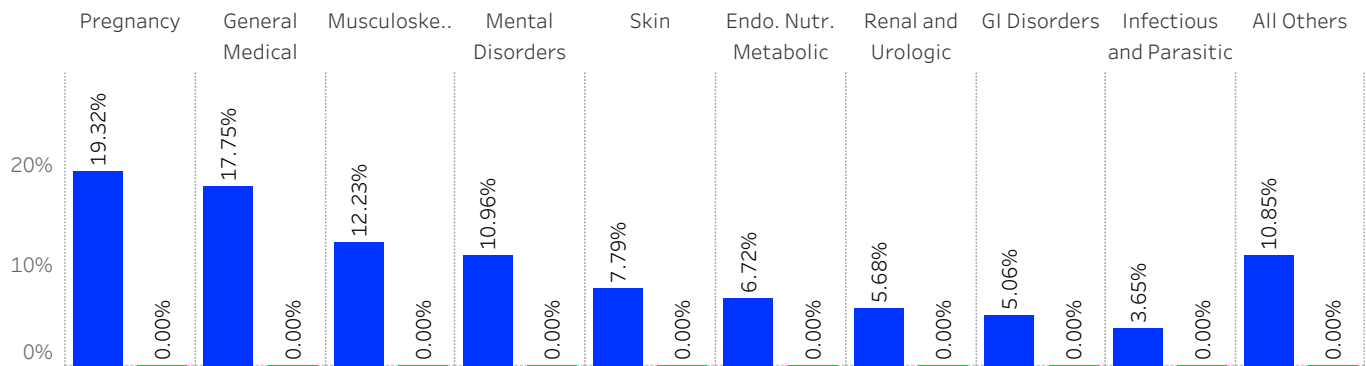


Medical Top Diagnostic Categories

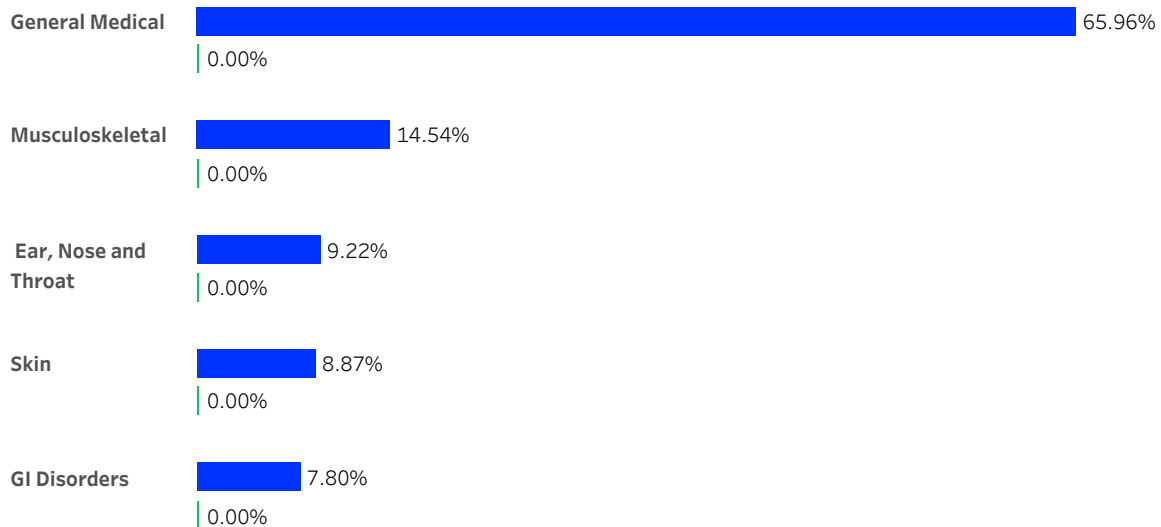
Sep 2025 - Mar 2026

Louisiana Tech University

% Of Spend By MDC



Top 5 Medical Condition: % Of Population



Current

Prior

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