

**GLOBAL STUDENT APEX
PREMIERE PLAN
KOREAN STUDENT ASSOCIATION STUDENT HEALTH INSURANCE**

GENERAL FEATURES/PLAN SPECIFICATIONS ¹			
Annual Maximum Per Injury or Sickness (Per policy year) ²	\$1,000,000		
Lifetime Maximum Per Covered Person	Unlimited		
Area of Coverage	United States		
Outside of the United States including Home Country Coverage	\$500		
	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Annual Individual Deductible (Per policy year) ³ • Family Deductible is 3 times Individual	\$250	\$250	\$500
Member Coinsurance (after the deductible)	80%	80%	60%
Individual Out-of-Pocket Maximum (Coinsurance Maximum) ⁴ • Family Out-of-Pocket is 3 times Individual	\$6,350	\$6,350	Unlimited
Office Visit Co-payment, including Student Health Center • Doctor Non-Surgical Treatment/Examination • Consultation visits when referred by the attending Doctor	\$25 \$50	\$25 \$50	\$50
Prescription Drug Benefits	80%		
Preventive Care	Covered		
Routine Dental	Not Covered		
Routine Vision	Not Covered		
Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payments, and Benefit Maximum.	PLAN REIMBURSEMENT Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
Hospitalization and Inpatient Benefits: <i>Pre-Authorization Required</i>			
<ul style="list-style-type: none"> • Semi-private room • Intensive Care (medically necessary) • Medical treatment, medicines, laboratory and diagnostic tests • Inpatient Consultation by a Physician or Specialist • Inpatient Surgery • Inpatient Surgeon • Inpatient Ancillary Services 	80%	80%	60%
Outpatient Benefits			
<ul style="list-style-type: none"> • Emergency Room • Emergency Medical Services • Outpatient Physician Visit • Consultation by Specialist • Echocardiography, Ultrasound, • CAT Scan, PET Scan, MRI • Endoscopy (e.g. gastroscopy, colonoscopy, cystoscopy) • X-Rays • Laboratory 	80%	80%	60%

¹ Benefits will be paid on a reasonable and customary basis, subject to all Policy exclusions, limitations and conditions for charges listed if they are incurred as a result of sickness or accidental bodily injury and the benefits must also be medically necessary and given or ordered by a physician.

² All references to Annual refer to a Policy Year, not a calendar year.

³ The Deductible for "Outside U.S." and "U.S. In-Network" is combined. The Deductible for "U.S. Out-of-Network" is separate.

⁴ The Annual Out-of-Pocket Maximum for "Outside U.S." and "U.S. In-Network" is combined. The Annual Out-of-Pocket Maximum for "U.S. Out-of-Network" is separate.

<ul style="list-style-type: none"> • Outpatient or Ambulatory Surgery • Outpatient Surgeon 			
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Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payments, and Benefit Maximum.	PLAN REIMBURSEMENT		
	Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Emergency Room			
<ul style="list-style-type: none"> • Deductible \$300, waived if admitted 	100%	100%	100%
Maternity – conception must occur while this coverage is in effect;			
<ul style="list-style-type: none"> • Normal delivery including prenatal care, postnatal care and complications of pregnancy. • Dependent Daughters are not covered. • Fertility/infertility services, tests, treatments, drugs and/or procedures, complications of that pregnancy, delivery and postpartum care are excluded from coverage. 	80%	80%	60%
Premature Birth, Congenital Conditions, Birth Anomalies for a Newborn Baby			
Premature birth, congenital conditions, birth anomalies are covered if the child was born while effective under this plan and the pregnancy was a covered service.	80%	80%	60%
Therapeutic Services (Outpatient)			
Physical Therapy, Chiropractic, Occupational Therapy, Vocational Speech Therapy			
\$70 per visit, maximum 30 days per occurrence	80%	80%	60%
Homeopathic and Acupuncture			
<ul style="list-style-type: none"> • Treatment for a covered illness 	80%	80%	60%
**Annual Maximum Benefit: \$500			
Human Organ, Bone Marrow, Stem Cell Transplants, and other Similar procedures: Pre-Authorization Required			
<ul style="list-style-type: none"> • Expenses for Donor are not covered including search fees and medical expenses 	80%	80%	60%
Extended Care / Inpatient Rehabilitation: Pre-Authorization Required			
<ul style="list-style-type: none"> • Must be confined to facility immediately following a Hospital stay • Acute or Sub-Acute Care only for Extended Care Episode 	80%	80%	60%
Hospice			
<ul style="list-style-type: none"> • Refer to Policy regarding qualifications for care 	80%	80%	60%
** Inpatient Lifetime Benefit Maximum: 45 Days			
**Outpatient Lifetime Benefit Maximum: \$5,000			
Emergency Ambulance			
<ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance: Pre-Authorization Required • Refer to Policy for more specific details 		100%	
Durable Medical Equipment: Pre-Authorization Required			
<ul style="list-style-type: none"> • Reimbursement of rental up to purchase price • See Policy for more specific details 	80%	80%	60%
Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing: Pre-Authorization Required			
<ul style="list-style-type: none"> • Refer to Policy for specific details 	80%	80%	60%
**Annual Benefit Maximum: 100 Days Per Year			

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Covered Services and Benefit Levels: Subject to Deductible, Coinsurance, Co-payment, and Benefit Maximum.	PLAN REIMBURSEMENT		
	Once the Annual Out-of-Pocket Maximum (Coinsurance Maximum) is met, the Plan reimbursement is 100%		
	Outside U.S.	U.S. In-Network	U.S. Out-of-Network
Diabetic Supplies: <i>Pre-Authorization Required</i>			
<ul style="list-style-type: none"> Includes Insulin Pumps and associated supplies **Annual Maximum Benefit: \$5,000	80%	80%	60%
Mental Health			
**Lifetime Benefit Maximum: \$25,000 Outpatient; \$5,000 Inpatient **Inpatient: Annual Benefit Maximum: 30 days; * *Outpatient: Annual Benefit Maximum: 40 visits	80%	80%	60%
Alcohol and Drug Abuse: Out-patient & In-patient; <i>Pre-Authorization Required</i>			
<ul style="list-style-type: none"> Rehabilitative treatment only 	80%	80%	60%
HIV, AIDS, ARC and Sexually Transmitted Diseases			
Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions <ul style="list-style-type: none"> Treatment available if condition is not pre-existing 	80%	80%	60%
Emergency Dental Care			
<ul style="list-style-type: none"> Limited to accidental injury of sound natural teeth sustained while covered under the policy Covered under the medical benefit and not the Optional Dental Benefit ** Benefit Maximum: \$300 per tooth	100%**	100%**	80%**
Preventive Care			
Child Wellness			
<ul style="list-style-type: none"> Includes child immunizations and routine medical exams Up to 12 months of age **Maximum 9 visits	100%**	100%**	80%**
Adult Female and Male Examinations, Mammograms and Immunizations Covered			
Other Benefits			
Repatriation of Remains	\$20,000 Maximum Benefit		
War and Terrorism	Included		
Accidental Death and Dismemberment	\$15,000 Maximum Benefit		

Covered Medical Expenses:

When a covered Injury or Sickness requires treatment by a Physician, the coverage will provide benefits for the Reasonable and Customary Charges for Medically Necessary Covered Medical Expenses, which exceed the deductible per person for each Injury or Sickness. Payment for any Covered Medical Expense will be no more than the Benefit Limit shown for it. The total payable for all Covered Medical Expenses will be no more than the Maximum Benefit Limit per Sickness or Injury. Benefits are subject to the Excess Provision.

- 1 Room and Board Expense:
 - a) Daily semi-private room rate when Hospital Confined;
 - b) General nursing care provided and charged for by the Hospital up to PPO allowable in network and \$1,000/day out of network
 - c) Maximum 30 days per occurrence;
- 2 Ancillary Hospital Expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined. This does not include personal services of a non-medical nature. Doctor's surgical expenses are not covered under this expense.
- 3 Daily Intensive Care Unit Expenses: the daily room rate when a Covered Person is Hospital Confined in a bed in the Intensive Care Unit and nursing services other than private duty nursing services;
- 4 Medical Emergency care (room and supplies) Expenses: incurred within 72 hours of an Accident and including the attending Doctor's charges, X-rays, laboratory procedures, use of the emergency room and supplies subject to co-payment of \$300 per occurrence. If a covered Person is admitted to the hospital following visit to the emergency room, the co-payment is waived;
- 5 Any child born to the Insured on or after the effective date, will be covered for the first 31 days after birth. Coverage for such child will be for injury or Sickness including medically diagnosed congenital defects, birth abnormalities, prematurity, and nursery care when the child is sick or injured. To continue coverage beyond 31 days, written application and payment of any required premium must be made.
- 6 Outpatient Surgical Room and Supply Expenses for use of the surgical facility;
- 7 Outpatient diagnostic X-rays, laboratory procedures and tests;
- 8 Doctor Non-Surgical Treatment/Examination Expenses subject to \$25 co-pay. Consultation visits when referred by the attending Doctor, subject to \$50 co-pay.
- 9 Doctor's Surgical Expense subject to maximum of \$3,000 per occurrence;
- 10 Assistant Surgeon Expenses when Medically Necessary;
- 11 Anesthesiologist Expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis;
- 12 Outpatient Laboratory Test Expenses;
- 13 Physiotherapy Physical Medicine/Chiropractic/Acupuncture Expenses on an inpatient or outpatient basis limited to \$70 per visit 30 days maximum per occurrence. Expenses include treatment and office visits connected with such treatment when prescribed by a Doctor, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy;
- 14 X-ray Expenses (including reading charges) but not for dental X-rays;
- 15 Dental Treatment: 1) performed by a Physician; and 2) made necessary by Injury to Sound, Natural Teeth. \$300. Routine dental care and treatment to the

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gums are not covered;

- 16 Outpatient Registered Nurse Services if ordered by a Doctor;
- 17 Ambulance Expenses for transportation from the emergency site to the Hospital;
- 18 Rehabilitative braces or appliances prescribed by a Doctor. It must be durable medical equipment that
 - a) is primarily and customarily used to serve a medical purpose;
 - b) can withstand repeated use;
 - c) generally is not useful to a person in the absence of Injury .No benefits will be paid for rental charges in excess of the purchase price;
- 19 Prescription Drug Expenses including dressings, drugs and medicines prescribed by a Doctor and administered on an outpatient basis. 80% of Reasonable & Customary.
- 20 Medical Equipment Rental Expenses for a wheelchair or other medical equipment that has therapeutic value for a Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids;
- 21 Medical Services and Supplies: expenses for blood and blood transfusions; oxygen and its administration;
- 22 Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment;
- 23 Mental and Nervous Disorder (Outpatient) benefits are limited to 1 visit per day to a maximum of 40 visits, \$5,000 maximum, per coverage year, payable at 80% In-Network and 60% Out-of-Network;
- 24 Mental and Nervous Disorders (Inpatient) benefits are limited to 1 visit per day up to a maximum of 30 visits per policy year, payable at 80% In-Network and 60% Out-of-Network;
- 25 Therapeutic termination of pregnancy;
- 26 Maternity (conception must occur while this coverage is in effect);
- 27 Alcoholism/Drug Abuse Treatment: the benefits and the maximum amounts are the same as any Sickness.
- 28 Pre-existing conditions.

Excess Provision: All benefits shall be in excess of all other valid and collectible insurance and shall apply only when such benefits are exhausted. If an Insured's Injury or Sickness is due to an act or omission of another, benefits payable by this plan are subject to recovery from amounts eventually paid to the Insured by or on behalf of the other person.

EXCLUSIONS

- 1 No benefits will be paid for loss or expense caused by, enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a Physician;
- 2 For routine physical, immunizations or other examination where there are no objective indications or impairment in normal health, and laboratory diagnostic or X-ray examination except in the course of a disability established by the prior call or attendance of a physician;
- 3 Eye examinations; prescriptions or fitting of eyeglasses and contact lenses;
- 4 Hearing examinations or hearing aids; or other treatment for hearing defects and problems;

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- 5 Dental treatment, except as the result of Injury to Sound, Natural Teeth as stated in the Covered Medical Expenses;
- 6 Professional services rendered by a member of the Insured Person's immediate family, or anyone who lives with the Insured Person;
- 7 Services or supplies not necessary for the medical care of the patient's Injury or Sickness;
- 8 Weak, strained or flat feet, corns, calluses, or toenails;
- 9 Cosmetic surgery, or treatment for congenital anomalies (except as specifically provided), except reconstructive surgery as the result of a covered Injury or Sickness. Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered Injury or Sickness;
- 10 Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
- 11 Injury sustained while participating in an intercollegiate, semi-professional or professional sport.
- 12 Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- 13 Organ transplants;
- 14 War while in the armed forces of any country (a pro-rate premium will be refunded upon request for such period not covered);
- 15 Participation in a riot or civil disorder; commission of or attempt to commit a felony in the country in which it was attempted or committed;
- 16 Suicide or attempted suicide (including drug overdose) while sane or insane (while sane in Missouri); or intentionally self-inflicted Injury (may vary by state);
- 17 Charges of an institution, health service, or infirmary for whose service payment is not required in the absence of insurance;
- 18 Loss incurred from riding in any aircraft, other than as a passenger in an aircraft licensed for the transportation of passengers;
- 19 Duplicate services actually provided by both a certified nurse-midwife and Physician;
- 20 Expenses payable under any prior policy which was in force for the person making the claim;
- 21 Expenses incurred during a Hospital emergency room visit which is not of an emergency nature;
- 22 Expenses incurred for outpatient treatment in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
- 23 Medical expense resulting from a motor vehicle accident in excess of that which is payable under any valid and collectible insurance;
- 24 Pregnancy or childbirth (except when conception occurs while this coverage is in effect); elective abortion; elective cesarean section; pregnancy or childbirth for a dependent when dependent child of an Insured Student (except for complications arising there from);
- 25 Expenses covered by any other valid and collectible medical, health or accident insurance;
- 26 Expenses incurred after the date insurance terminates for an Insured Person;
- 27 Expenses incurred for injuries resulting from the use of alcohol or intoxicants, or any drugs unless prescribed by a Physician;
- 28 For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary

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and reasonable by a physician;

- 29 For the ordinary cost of a one way airplane ticket used in the transportation back to the Insured's country where an air ambulance benefit is provided and medically necessary;
- 30 For specific named hazards: motorcycling, scuba diving, jet, snow or water skiing, ski activity, snowboarding, mountain climbing (where ropes or guides are used), sky diving, professional or amateur racing, piloting an aircraft, bungee jumping, spelunking, whitewater rafting, surfing (unless part of a school credit course), and parasailing;
- 31 Treatment paid for or furnished under any other individual or group policy, or other service or medical pre-payment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for the treatment without cost to any individual;
- 32 Treatment of Acne;
- 33 Covered medical expenses for which the Covered Person would not be responsible for in the absence of this coverage;
- 34 Conditions that are not caused by a Covered Accident or Sickness

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