2006-2007

STUDENT INJURY AND SICKNESS INSURANCE PLAN

"Discount Plan"

Designed Especially For

International Community Service

The Policy is a Non-Renewable One Year Term Policy

Eligibility: All regular, full time and part time eligible students, scholars, or other persons with a current passport who: 1) are engaged in international educational activities; and 2) are temporarily located outside his/her home country as a non-resident alien; and 3) have not obtained permanent residency status are eligible to enroll in this Plan on a Voluntary basis. Those enrolled in an Optional Practical Training program (with a F-1 or J-1 visa) who were previously enrolled in this Plan are eligible. Eligible Dependents of insured students may enroll concurrently on a Voluntary basis.

The named insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased, with the exception of those with a J Visa or those in an Optional Practical Training program.

Please be aware that each eligible student has a choice of one of the (3) benefit Plans. Make your Plan selection carefully; you cannot change your Plan selection after the initial purchase of the Plan for this Policy Year.

The Preferred Providers for this plan are **Beech Street, Inc.***
**except specific state plans as listed below:*

Florida Preferred Provider is SouthCare	(201596-93)
Massachusetts Preferred Provider is HCVM	(201592-93)
New York Preferred Provider is Multi-Plan	(201593-93)
Virginia Preferred Provider is Alliance	(201591-93)

NOTICE: Benefits may vary by state or coverage may not be available in all states. This plan is not available in Hawaii, Kentucky, Maine, Maryland, Missouri, Montana, Nevada, New Jersey, North Carolina, Oklahoma, Oregon, Pennsylvania, Puerto Rico, and Washington.

06-201293-93
Revised 8/8/2006

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:

    (a) On the date the Named Insured marries the Dependent; or
    (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent, unmarried child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid;
2) The date the policy terminates; or
3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

A copy of any application of the Policyholder shall be attached to the policy when issued. All statements made by the Policyholder or Insured Person shall be deemed representations and not warranties. No written statement made by any Insured Person shall be used in any contest unless a copy of the statement is furnished to the Insured or to his beneficiary or personal representative.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

GRACE PERIOD: A grace period of thirty-one days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIMS EXPERIENCE. The Company, upon request, shall provide the Policyholder with a complete record of the Policyholder's claims experience incurred under the policy. This record shall include all claims incurred for the lesser of: 1) the period of time since the policy was issued or issued for delivery, or 2) the period of time since the policy was last renewed, reissued or extended, if already issued. This record shall be made available promptly to the Policyholder upon request made not less than thirty days prior to the date upon which the premiums or contractual terms of the policy may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under Virginia Statutes.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid within 60 days after receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All benefits are payable to the Insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Subject to any written direction of the Insured, all or a portion of any benefits payable under this policy may be paid directly to the Hospital, Physician or person rendering the service or treatment. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. This provision in no way intends to secure subrogation rights for the Company against a third party.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

CONVERSION PRIVILEGE: Subject to filing of proper application on forms supplied by the Company and payment of applicable premium within 31 days following termination of coverage, the Named Insured will be eligible to have issued to him without evidence of insurability an individual policy of Hospital-Medical-Surgical insurance. The individual policy shall be on a plan then customarily issued by the Company, not greater than provided by this policy, at premium rates applicable to the Named Insured's attained age as of the date of conversion. Dependents insured by this policy as of its date of termination shall also be eligible for coverage under the Named Insured's individual policy.

INCONTESTABILITY: The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. The Company reserves the right to contest the validity of the policy for up to two years from its date of issue. No statement made by any person insured under the policy relating to his insurability or the insurability of his insured Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: 1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and 2) unless the statement is contained in a written instrument signed by him. This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

INDIVIDUAL CERTIFICATES: The Company will issue to the Policyholder an individual certificate for delivery to each Insured setting forth: 1) the Insured Person's insurance protection, including any limitations, reductions, and exclusions applicable to the coverage provided; 2) to whom the insurance benefits are payable; 3) any family member's or Dependent's coverage; and 4) the rights and conditions set forth in the "Conversion Privilege" provision of this policy as required by 38.2-3541 of the Virginia Insurance Code.

PART III
DEFINITIONS

ADOPTED OR NEWBORN CHILD means: 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Such child will be covered under the policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption, unless the placement is disrupted prior to final decree of adoption, and the child is removed from placement with the Insured. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity, nursery care; inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the date of birth, adoption, or placement for adoption: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of birth, adoption, or placement for adoption.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and, pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CREDITABLE COVERAGE means (1) Medicare or Medicaid; (2) an employer-based health insurance or benefit plan with similar benefits to this policy; (3) an individual policy; health maintenance organization; Multiple Employer Welfare Arrangement; fraternal benefit society; nonprofit medical and surgical plan or hospital service plan that provides similar benefits to this policy; if the policy has been in effect for at least one year; or an employee benefit plan subject to ERISA; (4) Armed Forces Personnel Medical and Dental Care; (5) Indian Health Service or tribal medical care program; (6) a state health benefits risk pool; (7) Federal Employees Health Benefit Plan; (8) a public health plan; (9) the Peace Corps Act health benefit plan; (10) church plan; or (11) college plan.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children and children that the Insured must provide coverage due to court order. Children shall cease to be dependent on the first to occur of:

1) The end of the month in which they marry; or,
2) The end of the month in which they attain the age of nineteen (19) years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

For the treatment of Mental and Nervous Disorder/Alcohol and Drug Dependence, Hospital also means a licensed alcohol or drug rehabilitation facility, intermediate care facility, and mental health treatment facility. These facilities are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

1) Death;
2) Placement of the Insured's health in jeopardy;
3) Serious impairment of bodily functions;
4) Serious dysfunction of any body organ or part; or
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioral disorder. Mental and Nervous Disorder does not mean a Mental Illness as defined in the Benefits for Biologically Based Mental Illness. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months immediately prior to the Insured's Effective Date under this policy.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

PSYCHOTHERAPY means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

PART IV

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured incurs medical expenses within 30 days of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues:

1) When not Hospital Confined on the Termination Date, not to exceed 90 days after the Termination Date; or
2) When Hospital Confined on the Termination Date, not to exceed 12 months after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.

PART IV
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – DISCOUNT PLAN
2006-201591-93
INJURY AND SICKNESS BENEFITS

Maximum Benefit	**$100,000 (For Each Injury or Sickness)**
Deductible	**-0-**
Preferred Provider Coinsurance	**80% except as noted below**
Out-of-Network Coinsurance	**60% except as noted below**

Each eligible student has a choice of one of the (3) benefit Plans. Make your Plan selection carefully; you cannot change your Plan selection after the initial purchase of the Plan for this Policy Year.

The Preferred Providers for this plan are Alliance in Virginia and Beech Street when outside of Virginia.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits.

Preferred Provider: The Company will pay 80% of Covered Medical Expenses up to $35,000 then 100% of Covered Medical Expenses up to the Maximum Benefit of $100,000.

The benefits payable are as defined in and subject to all provisions of this policy and any riders or endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

Inpatient	**Preferred Provider**	**Out-of-Network**
Room & Board / Hospital Misc.:	Preferred Allowance/$100 co-pay per day for 1st 3 days	Usual & Customary Charges/$100 Deductible per day for 1st 3 days
Intensive Care:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Routine Newborn Care:	Paid as any other Sickness/4 days maximum	Paid as any other Sickness/4 days maximum
Physiotherapy: *($2,500 maximum total for Inpatient and Outpatient combined.)*	Preferred Allowance/$2,500 maximum	Usual & Customary Charges/$2,500 maximum
Surgery: *(Specified surgery based on data provided by Ingenix.)*	Preferred Allowance/$7,500 maximum	Usual & Customary Charges/$7,500 maximum
Assistant Surgeon:	Paid under Surgery	Paid under Surgery
Anesthetist:	Paid under Surgery	Paid under Surgery
Registered Nurse's Services:	Preferred Allowance	Usual & Customary Charges
Physician's Visits:	Preferred Allowance	Usual & Customary Charges
Pre-admission Testing:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Mental Illness/Substance Abuse:	See Benefits for Mental Illness/Substance Abuse	See Benefits for Mental Illness/Substance Abuse
Biologically Based Mental Illness: *(See Benefits for Biologically Based Mental Illness.)*	Paid as any other Sickness	Paid as any other Sickness

Outpatient	**Preferred Provider**	**Out-of-Network**
Surgery: *(Specified surgery based on data provided by Ingenix.)*	Preferred Allowance /$7,500 maximum	Usual & Customary Charges/$7,500 maximum
Day Surgery Miscellaneous: *(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)*	Preferred Allowance/$5,000 maximum / $100 co-pay	Usual & Customary Charges/$5,000 maximum/$100 Deductible
Assistant Surgeon:	Paid under Surgery	Paid under Surgery
Anesthetist:	Paid under Surgery	Paid under Surgery
Physician's Visits:	Preferred Allowance/$20 co-pay per visit	Usual & Customary Charges/$ 20 Deductible per visit
Physiotherapy:	Preferred Allowance/$2,500 maximum	Usual & Customary Charges/$2,500 maximum

($2,500 maximum total for Inpatient and Outpatient combined). (Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)

SCHEDULE OF BENEFITS *(Continued)*
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – DISCOUNT PLAN
2006-201591-93
INJURY AND SICKNESS BENEFITS

Outpatient *(Continued)*	**Preferred Provider**	**Out-of-Network**
Outpatient Misc. Benefits:	No Benefits	No Benefits
Medical Emergency:	Preferred Allowance/$75 co-pay per visit	80% of Usual & Customary Charges/$75 Deductible per visit
X-rays & Laboratory:	Preferred Allowance/$20 co-pay per test	Usual & Customary Charges/$20 Deductible per test
Radiation Therapy/Chemotherapy:	Preferred Allowance/$1,000 maximum/ $20 co-pay per visit	Usual & Customary Charges/$1,000 maximum/$20 Deductible per visit
Tests & Procedures:	Preferred Allowance/$20 co-pay per test	Usual & Customary Charges/$20 Deductible per test
Prescription Drugs:	75% of Usual & Customary Charges/$2,000 maximum (Per Policy Year)	75% of Usual & Customary Charges/$2,000 maximum (Per Policy Year)
Mental Illness/Substance Abuse:	See Benefits for Mental Illness/Substance Abuse	See Benefits for Mental Illness/Substance Abuse
Biologically Based Mental Illness: (See Benefits for Biologically Based Mental Illness)	Paid as any other Sickness	Paid as any other Sickness

Other		
Ambulance: *(includes ground and air transportation.)*	Usual & Customary Charges/$150 maximum	Usual & Customary Charges/$150 maximum
Durable Medical Equipment:	Usual & Customary Charges	Usual & Customary Charges
Consultant:	Preferred Allowance	Usual & Customary Charges
Dental: *(Injury to Sound, Natural Teeth only.)*	Usual & Customary Charges/$100 maximum per tooth/$500 maximum (Per Policy Year)	Usual & Customary Charges/$100 maximum per tooth/$500 maximum (Per Policy Year)
Maternity:	Paid as any other Sickness	Paid as any other Sickness
(If an Insured is pregnant on the Termination Date and the conception occurred while covered under this policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.)		
Elective Abortion:	Paid as any other Sickness/$500 maximum (Per Policy Year)	Paid as any other Sickness/$500 maximum (Per Policy Year)
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
Medical Evacuation:	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
***AD&D:**	See Endorsement	See Endorsement
Intercollegiate Sports:	No Benefits	No Benefits
MRI/Cat Scan:	Preferred Allowance/$1,200 maximum (Per Policy Year)/$100 co-pay per test	Usual & Customary Charges/$1,200 maximum (Per Policy Year)/$100 Deductible per test
Child Health Assurance:	Preferred Allowance	Usual & Customary Charges

(The benefits shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age. "Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Minimum Benefits are limited to one visit payable to one provider for all services provided at each visit. Benefits shall not be subject to the Deductible, but are subject to all copayment, coinsurance, limitations, or any other provisions of the policy.)

SCHEDULE OF BENEFITS *(Continued)*
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – DISCOUNT PLAN
2006-201591-93
INJURY AND SICKNESS BENEFITS

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

Conversion Permitted: Yes (X) No ( ) **Continuation Permitted:** Yes ( ) No (X)

SHC Referral Required: Yes ( ) No (X) ***Pre-Admission Notification:** Yes (X) No ( )

( ) **52 week Benefit Period** or (X) **Extension of Benefits**

Other Insurance: (X) ***Coordination of Benefits** ( ) **Primary Insurance**

*If benefit is designated, see rider or endorsement attached.

PREFERRED PROVIDER INFORMATION

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are Alliance in Virginia and Beech Street when outside of Virginia.

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"**Preferred Allowance**" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out of Network" providers have not agreed to any prearranged fee schedules. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Preferred Providers will be paid at the coinsurance percentages or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** See the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for 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. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. The benefits and the maximum amounts are specified in the Schedule of Benefits.

5. **Physiotherapy (Inpatient):** See Schedule of Benefits.

6. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

7. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

8. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

10. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

12. **Mental Illness/Substance Abuse (Inpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and the specific benefit provision. Benefits are limited to one visit per day.

13. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

14. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

15. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

16. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

17. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.

18. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

19. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.

20. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

21. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

22. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

23. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

24. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

25. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.

26. **Chemotherapy (Outpatient):** See Schedule of Benefits.

27. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

28. **Mental Illness/Substance Abuse (Outpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and the specific benefit provision. Benefits are limited to one visit per day.

29. **Ambulance Services:** See Schedule of Benefits.

30. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.

31. **Consultant Physician Fees:** when requested and approved by the attending Physician.

32. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

33. **Maternity:** Same as any other Sickness.

34. **Complications of Pregnancy:** Same as any other Sickness.

35. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

36. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

37. **Supplemental Injury Benefit:** for treatment rendered: 1) on an inpatient or outpatient basis; 2) in a Physician's office or Hospital; and 3) as a result of Injury. This benefit will be paid prior to all other Basic benefits.

38. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

39. **Intercollegiate Sports:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VII
MANDATED BENEFITS

BENEFITS FOR PREGNANCY FROM RAPE OR INCEST

Benefits will be paid as for any other Injury for pregnancy resulting from an act of rape or incest which was reported to the police within 7 days, or 180 days if under 13 years of age, following the incident.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for low-dose screening Mammograms for determining the presence of occult breast cancer according to the following guidelines:

1. One screening Mammogram to persons age thirty-five through thirty-nine.

2. One Mammogram biennially to persons age forty through forty-nine.

3. One Mammogram annually to persons age fifty and over.

Benefits shall not exceed a maximum of $50.00 per Mammogram.

"Mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast. The equipment used to perform the mammogram must meet the radiation protection regulations standards set forth by the Virginia Department of Health.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PAP SMEARS

Benefits will be paid the same as any other Sickness for an annual pap smear performed by any FDA approved gynecologic cytology screening technologies.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness (1) for Insureds age fifty and over and (2) for Insureds age forty and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening. Coverage shall include an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or, in appropriate circumstances, radiologic imaging shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery. The reimbursement for Reconstructive Breast Surgery will be determined according to the same formula by which charges are developed for other medical and surgical procedures.

"Mastectomy" means the surgical removal of all or part of the breast.

"Reconstructive breast surgery" means surgery performed (1) coincident with or following a Mastectomy or (2) following a Mastectomy to reestablish symmetry between the two breasts, for Reconstructive Breast Surgery performed on or after October 21, 1998, and while the Insured is or was covered under the policy. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending Physician and Insured, and physical complications of Mastectomy, including medically necessary treatment of lymphedemas.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR INPATIENT COVERAGE FOLLOWING MASTECTOMY

Benefits will be paid the same as any other Sickness for a minimum of 48 hours of inpatient care following a radical or modified radical mastectomy and a minimum of 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR HYSTERECTOMY

Benefits will be paid the same as any other Sickness for a minimum of 23 hours Hospital stay for a laparoscopy-assisted vaginal hysterectomy and 48 hours for a vaginal hysterectomy. Nothing in this section shall be construed as requiring the total hours referenced when the attending Physician in consultation with the patient determines that a shorter period of Hospital stay is appropriate.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for Biologically Based Mental Illness.

"Biologically based mental illness" means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the Insured's functioning.

The following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children:

1. schizophrenia;
2. schizoaffective disorder;
3. bipolar disorder;
4. major depressive disorder;
5. panic disorder;
6. obsessive-compulsive disorder;
7. attention deficit hyperactivity disorder;
8. autism; or
9. drug and alcohol addiction.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE ABUSE

Benefits will be paid the same as any other Sickness for inpatient and partial hospitalization for mental illness and substance abuse services as follows:

1) Treatment for an adult as an inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty (20) days per policy year.

2) Treatment for a child or adolescent as an inpatient at a Hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of twenty-five (25) days per policy year.

3) Up to ten (10) days of the inpatient benefit set forth in (1) and (2) may be converted when medically necessary at the option of the person or the parent, as defined in Virginia Statute 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

Benefits will be paid the same as any other Sickness for outpatient mental illness and substance abuse services as follows:

1) A minimum of twenty (20) visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy year.
2) The limits of the benefits shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy year will be paid at 50% of Usual and Customary Charges.
3) Medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit.
4) If all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any Deductible required by the policy, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for diabetes. Benefits shall include equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR CLINICAL TRIALS FOR TREATMENT STUDIES ON CANCER

Benefits will be paid the same as any other Sickness for Patient Costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the Insured for purposes of a clinical trial. Patient cost does not include (1) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (2) costs associated with managing the research associated with the clinical trial, or (3) the cost of the investigational drug or device.

Coverage for Patient Costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. The treatment shall be provided by a clinical trial approved by:

(1) The National Cancer Institute (NCI);
(2) An NCI cooperative group or an NCI center;
(3) The Federal Food and Drug Administration (FDA) in the form of an investigational new drug application;
(4) The federal Department of Veterans Affairs; or
(5) An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

This benefit shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;
(2) The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
(3) The Insured and the Physician or health care provider who provides services to the Insured conclude that the Insured's participation in the clinical trial would be appropriate, pursuant to procedures established by the Company, as disclosed in the policy and evidence of coverage.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PRESCRIPTIONS FOR CANCER PAIN IN EXCESS OF RECOMMENDED DOSAGE

Benefits will be paid the same as any other Sickness for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer pain. Benefits will not be denied on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia Statutes 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PRESCRIPTION DRUGS FOR CANCER TREATMENT AND TREATMENT OF A COVERED INDICATION

Benefits will be paid for Prescription Drugs, including all services that are a Medical Necessity associated with the administration of the drug, to treat cancer subject to the following provisions.

Benefits will not be denied for any drug approved by the United States Food and Drug Administration (FDA) for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.

Benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.

"Standard reference compendia" means the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; or the United States Pharmacopoeia Dispensing Information.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;
2. Require coverage for any experimental drug not otherwise approved for any indication by the FDA;
3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA; or
4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR HOSPICE CARE

Benefits will be paid the same as any other Sickness for Hospice Services.

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team. "Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care. "Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Documentation requirements shall be no greater than those required for the same service under Medicare.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR HOME TREATMENT OF HEMOPHILIA AND CONGENITAL BLEEDING DISORDERS

Benefits will be paid the same as any other Sickness for the Home Treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Benefits include coverage for the purchase of Blood Products and Blood Infusion Equipment required for Home Treatment of routine bleeding episodes when the Home Treatment Program is under the supervision of the state-approved treatment center.

"Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

"State-approved hemophilia treatment center" means a Hospital or clinic which received federal or state Maternal and Child Health Bureau and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

"Blood infusion equipment' includes but is not limited to syringes and needles.

"Blood Product" includes but is not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR EARLY INTERVENTION SERVICES

Benefits will be paid the same as any other Sickness for medically necessary Early Intervention Services. Such coverage shall be limited to a benefit of $5,000 per Insured per policy year. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the Company to or on behalf of the Insured during the Insured's lifetime.

"Early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for Dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. These services are designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy except any lifetime provision.

BENEFITS FOR NEWBORN INFANT HEARING SCREENING

Benefits will be paid the same as any other Sickness for newborn infant hearing screenings and all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommended by the National Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such benefits shall include any follow-up audiological examinations as recommended by a Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR CHILDHOOD IMMUNIZATIONS

Benefits will be paid the same as any other Sickness for childhood immunizations for Dependent children from birth to thirty-six months. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other immunizations as may be prescribed by the Commissioner of Health.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR GENERAL ANESTHESIA AND HOSPITALIZATION FOR DENTAL CARE

Benefits will be paid the same as any other Sickness for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to an Insured who is determined by a licensed dentist in consultation with the Insured's treating Physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (a) is under the age of five, or (b) is severely disabled, or (c) has a medical condition and requires admission to a Hospital or outpatient surgery facility for dental care treatment.

For purposes of this provision, a determination of Medical Necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the Insured requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

PART VIII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Acne; acupuncture;

2. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;

3. Biofeedback;

4. Injections;

5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;

6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;

7. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;

8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

9. Elective Surgery or Elective Treatment;

10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when apart from the disease process;

11. Foot care including: care of corns, bunions (except capsular or bone surgery); calluses;

12. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;

13. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

15. Injury sustained while (a) participating in any interscholastic, high school, intramural, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

16. Organ transplants, including organ donation;

17. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;

18. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

19. Pre-existing Conditions; except for individuals who have been continuously insured under the International Community Service policy for at least 6 months. If an individual: (1) had coverage under Creditable Coverage as defined and (2) that coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this policy, the time under the previous plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition.

    Pre-existing Condition limitations will not apply:

    a) for individuals who, as of the last day of the thirty-day period beginning under the date of birth, are covered under Creditable Coverage;
    b) any child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage; or
    c) to pregnancy;

20. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
    b. Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use;
    c. Immunization agents, biological sera, blood or blood products administered on an outpatient basis; except as specifically provided in the Benefits for Home Treatment of Hemophilia and Congenital Bleeding Disorders;
    d. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    e. Products used for cosmetic purposes;
    f. Drugs used to treat or cure baldness; anabolic steroids used for body building;
    g. Anorectics - drugs used for the purpose of weight control;
    h. Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene;
    i. Growth hormones; or
    j. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

21. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

22. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study; except as specifically provided in the Benefits for Clinical Trials for Treatment Studies on Cancer;

23. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;

24. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the policy;

25. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

26. Nasal and sinus surgery, except for treatment of chronic purulent sinusitis;

27. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

28. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

29. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

30. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

31. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and

32. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COORDINATION OF BENEFITS PROVISION

Definitions

(1) **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

(2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage for which the parent pays the entire premium; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.

(3) **Primary:** The Plan which pays regular benefits.

(4) **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.

(5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

Effect on Benefits - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

(1) If the Insured's other Plan does not have Coordination of Benefits, that Plan pays first.

(2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

(3) Dependent Child/Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but

b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

c. However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(4) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Plan of the parent with custody of the child;
2. then, the Plan of the spouse of the parent with the custody of the child; and
3. finally, the Plan of the parent not having custody of the child.

(5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below.

Payment under this endorsement when added to payment under the "Basic Medical Expense Benefit" (and under Major Medical, if coverage is afforded under Major Medical) shall not exceed the policy Maximum Benefit.

For Loss Of:

	STUDENT	**SPOUSE**	**CHILD**
Life	$15,000	$5,000	$1,000
Two or More Members	$15,000	$5,000	$1,000
One Member	$ 7,500	$2,500	$ 500

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

PRE-ADMISSION NOTIFICATION

Avidyn should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

Avidyn is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre- notification is not a guarantee that benefits will be paid.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COMPLAINT RESOLUTION

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 800-767-0700. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.