

# 2006-2007

## STUDENT INJURY AND SICKNESS INSURANCE PLAN *“Vantage Plan”*

*Designed Especially For*

# International Community Service

*The Policy is a Non-Renewable One Year Term Policy*

International



Community Service

**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:*

<b>Florida</b> Preferred Provider is SouthCare	(201596-92)
<b>Maine</b> Preferred Provider is PHCS	(201589-92)
<b>Maryland</b> Preferred Provider is Alliance	(201590-92)
<b>New York</b> Preferred Provider is MultiPlan	(201593-92)
<b>North Carolina</b> Preferred Provider is MedCost	(201594-92)
<b>Pennsylvania</b> Preferred Provider is Devon	(201595-92)
<b>Virginia</b> Preferred Provider is Alliance	(201591-92)

**NOTICE:** Benefits may vary by state or coverage may not be available in all states. This plan is not available in Hawaii, Massachusetts, New Jersey, Oregon, Puerto Rico, and Washington.

**TABLE OF CONTENTS**

Eligibility and Termination Provisions	2
General Provisions	2
Definitions	4
Schedule of Benefits	9
Benefit Provisions	10
Mandated Benefits	14
Exclusions and Limitations	23

**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 eligibility or 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 insurance producer 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.

## GENERAL PROVISIONS (Continued)

**CONTESTABILITY OF COVERAGE:** The contract may not be contested, except for nonpayment of premiums, after it has been in force for 1 year from the date of issue. A statement made by any person covered under the policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 1 year during the person's lifetime. Absent fraud, each statement made by an applicant, group policyholder, or Insured Person is considered to be a representation and not a warranty. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the policy unless; (i) the statement is contained in a written instrument signed by the group policyholder or Insured Person, and (ii) a copy of the statement is given to the group policyholder, Insured Person or beneficiary of the Insured Person.

**CERTIFICATES:** Unless the company makes delivery directly to the Insured Person, the policyholder will deliver to the Insured Person a certificate that summarizes the essential features of the insurance coverage including to whom benefits under the policy are payable.

**PAYMENT OF PREMIUM:** All premiums are payable in advance for each policy term in accordance with the Company's premium rates. New entrants will be added from time to time to the group originally insured. A pro-rata or reduced premium payment will be available to new entrants enrolling for the spring or summer as indicated on the policy face page. The pro-rata premium is calculated by dividing the annual premium by twelve; multiplying this amount by the number of months remaining in the policy year times a 15% premium loading fee. There will be no refunds to students who cancel coverage under the policy, unless the Insured enters the armed forces.

**GRACE PERIOD:** A grace period of 30 days will be granted for payment of each premium due after the first premium, unless the Company does not intend to renew the policy beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the Policyholder at least 45 days before the premium is due. During the grace period the policy shall continue in force.

**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. Failure to provide notice of claim within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish notice of claim within the time required and that notice of claim was submitted as soon as was reasonably possible.

**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 within the time required and that proof or loss was submitted as soon as was reasonably possible.

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under this policy for any loss will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities provided by this policy will be payable to the Named Insured unless the Named Insured requests in writing not later than the time of filing proofs of such loss that payment be made directly to the Hospital or person rendering such service. Any accrued indemnities unpaid at the Named Insured's death may, at the option of the Company, be paid to the estate of the Named Insured or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay up to an amount not exceeding \$5,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

**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 withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received.

**STANDARD OF TIME:** All times referenced shall be at the place the policy is delivered.

**MISSTATEMENT OF AGE:** If the age of an Insured has been misstated, the Insured shall be responsible for payment of any additional premium due had coverage been purchased at the correct issue age. The Company shall furnish notice to the Insured of such additional premium due. Additional premium that is not paid within 31 days from the date of notice of additional premium due may, at the election of the Company, be deducted from any claim payment then due and payable.

**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.

**SUBROGATION:** The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. Allowances will be made for legal fees and court costs in pursuing a settlement. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

**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.

**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.

### **PART III DEFINITIONS**

**ADOPTED CHILD** means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured must notify the Company, in writing, of the adopted child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

Benefits will also be provided for another child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

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 child's date of placement: 1) apply to us; 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 child's date of placement.

**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: 1) that portion of charges which are not in excess of Usual and Customary Charges; 2) that portion of charges which are not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) charges which are made for services and supplies not excluded under the policy; and 4) charges which are made for services included in the Schedule of Benefits.

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 benefits or coverage provided under: (i) an employer-sponsored plan; (ii) health benefit plan; (iii) Medicare or Medicaid, (iv) civilian health and medical program for uniformed services (CHAMPUS), (v) the Indian health service program, (vi) state health benefits risk pool, (vii) any other publicly sponsored health plan, or (viii) health plan offered under the Federal Employees Health Benefits Program, or (ix) any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean the amount of Covered Medical Expenses for which no benefits are payable under the policy. The deductible is subtracted from the amount or amounts otherwise payable as Covered Medical Expenses. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

## **DEFINITIONS** *(Continued)*

**DEPENDENT** means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children and children the Named Insured is under a court order to provide coverage.

If the Named Insured is under a court order to provide coverage, the following apply:

- 1) the Insured will be allowed to include the child in the coverage regardless of any enrollment period restrictions;
- 2) if the Insured has coverage but does not include the child in the enrollment then:
  - a) the noninsuring parent, child support enforcement agency, or the Department of Health and Mental Hygiene may apply for coverage on behalf of the child; and
  - b) the child may obtain coverage regardless of any enrollment period restrictions.
- 3) coverage for the child may not be terminated unless the following written evidence is provided:
  - a) the court order is no longer in effect;
  - b) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
  - c) the school has eliminated dependent coverage for all of its students; or
  - d) the Insured is no longer a student.
- 4) if the child has coverage through an Insured parent, the Company will:
  - a) provide membership cards or any other information necessary for the child to obtain benefits to the noninsuring parent; and
  - b) process the claims and make appropriate payment to the noninsuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

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-support because of mental or physical incapacity; 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 incapacitated as defined by subsections (1) and (2). The regular dependent premium will be charged to continue coverage for mentally or physically incapacitated dependent children.

## DEFINITIONS (Continued)

**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, or an institution specializing in or primarily treating Mental and Nervous Disorder. For the treatment of acute Mental and Nervous Disorder only, the requirement to provide facilities for major surgery is waived and hospital shall mean mental hospitals and institutions, public or private.

**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 an accident which is unrelated to any pathological, functional, or structural disorder; 2) a source of loss; 3) treated by a Physician within 30 days after the date of accident; and 4) sustained 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 injury. 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.

**IMMEDIATE FAMILY** means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

**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 including the sudden and unexpected onset of a condition involving severe pain. 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

**MENTAL ILLNESS, EMOTIONAL DISORDER** means a Sickness that is a mental, emotional or behavioral disorder. 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.

## **DEFINITIONS (Continued)**

**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.

**NEWBORN INFANT** means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent. The Pre-existing Conditions limitation will not apply to newborn infants.

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 child's birth: 1) apply to us; 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 child's birth.

**OUTPATIENT** means outpatient and out-of-hospital medical services.

**PHYSICIAN** means a health care provider, including a Community Health Resource, as defined in s. 19-2101 of the Health—General Article, who is: 1) duly licensed under the Health Occupations Article; and 2) acting within his/her lawful scope of practice; and 3) not a member of the Insured Person's Immediate Family. Physicians who make referrals prohibited by §1-302 of Health Occupations Article will not be eligible for reimbursement.

**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 a 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 the policy. Pregnancy will not be considered a pre-existing condition.

**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 Illness, Emotional 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 : 1) first manifests itself while the Insured Person is covered under this policy; and 2) causes incurred Covered Medical Expenses commencing 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.

**TOTALLY DISABLED** means a condition of a Named Insured which because of Sickness or Injury renders the Insured unable to actively attend classes. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

**USUAL AND CUSTOMARY CHARGES** means a 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 is Totally Disabled on 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 Insured remains Totally Disabled but not to exceed 12 months after the Termination Date. Proof of total disability may be required at any time.

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.

**PART IV  
SCHEDULE OF BENEFITS  
MEDICAL EXPENSE BENEFITS  
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN  
2006-201590-92  
INJURY AND SICKNESS BENEFITS**

<b>Maximum Benefit</b>	<b>\$250,000 (For each Injury or Sickness)</b>
<b>Deductible</b>	<b>\$100 (For each Injury or Sickness)</b>
<i>(The maximum Deductible for any one Insured will not exceed \$500 Per Policy Year)</i>	
<b>Preferred Provider Coinsurance</b>	<b>80% except as noted below</b>
<b>Out-of-Network Coinsurance</b>	<b>70% except as noted below</b>

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

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits 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.

The Deductible will be reduced to \$50 if treatment is received at a Recognized Student Health Center. All co-pays and Deductibles listed below are in addition to the Policy Deductibles.

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.

<b>Inpatient</b>	<b>Preferred Provider</b>	<b>Out-of-Network</b>
<b>Room &amp; Board / Hospital Misc.:</b>	Preferred Allowance/\$100 co-pay per day for 1 <sup>st</sup> 3 days	Usual & Customary Charges/\$100 Deductible per day for 1 <sup>st</sup> 3 days
<b>Intensive Care:</b>	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
<b>Routine Newborn Care:</b>	See Benefits for Maternity Expense	See Benefits for Maternity Expense
<b>Physiotherapy:</b> ( <i>\$2,500 maximum total for Inpatient and Outpatient combined.</i> )	Preferred Allowance/\$2,500 maximum	Usual & Customary Charges/\$2,500 maximum
<b>Surgery:</b> ( <i>Specified surgery based on data provided by Ingenix.</i> )	Preferred Allowance	Usual & Customary Charges
<b>Assistant Surgeon:</b>	Paid under Surgery	Paid under Surgery
<b>Anesthetist:</b>	Paid under Surgery	Paid under Surgery
<b>Registered Nurse's Services:</b>	Preferred Allowance	Usual & Customary Charges
<b>Physician's Visits:</b>	Preferred Allowance	Usual & Customary Charges
<b>Pre-admission Testing:</b>	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
<b>Psychotherapy:</b>	See Benefits for Mental Illness, Emotional Disorders and Drug and Alcohol Abuse and Benefits for Residential Crisis Services	See Benefits for Mental Illness, Emotional Disorders and Drug and Alcohol Abuse and Benefits for Residential Crisis Services
<b>Outpatient</b>	<b>Preferred Provider</b>	<b>Out-of-Network</b>
<b>Surgery:</b> ( <i>Specified surgery based on data provided by Ingenix.</i> )	Preferred Allowance	Usual & Customary Charges
<b>Day Surgery Miscellaneous:</b> ( <i>Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.</i> )	Preferred Allowance/\$150 co-pay	Usual & Customary Charges/\$150 Deductible
<b>Assistant Surgeon:</b>	Paid under Surgery	Paid under Surgery
<b>Anesthetist:</b>	Paid under Surgery	Paid under Surgery
<b>Physician's Visits:</b>	Preferred Allowance/\$20 co-pay per visit	Usual & Customary Charges/\$20 Deductible per visit

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2005-201590-92**  
**INJURY AND SICKNESS BENEFITS**

<b>Outpatient (Continued)</b>	<b>Preferred Provider</b>	<b>Out-of-Network</b>
<b>Physiotherapy:</b>	Preferred Allowance/\$2,500 maximum	Usual & Customary Charges/\$2,500 maximum
<i>(\$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.)</i>		
<b>Outpatient Misc. Benefits:</b>	No Benefits	No Benefits
<b>Medical Emergency:</b>	Preferred Allowance/\$150 co-pay per visit	80% of Usual & Customary Charges/\$150 Deductible per visit
<b>X-rays &amp; Laboratory:</b>	Preferred Allowance/\$20 co-pay per test	Usual & Customary Charges/\$20 Deductible per test
<b>Radiation Therapy/Chemotherapy:</b>	Preferred Allowance/\$1,000 maximum	Usual & Customary Charges/\$1,000 maximum
<b>Tests &amp; Procedures:</b>	Preferred Allowance/\$20 co-pay test	Usual & Customary Charges/\$20 Deductible per test
<b>Injections:</b>	No Benefits	No Benefits
<b>Psychotherapy:</b>	See Benefits for Mental Illness, Emotional Disorders and Drug and Alcohol Abuse and Benefits for Residential Crisis Services	See Benefits for Mental Illness, Emotional Disorders and Drug and Alcohol Abuse and Benefits for Residential Crisis Services
<b>Prescription Drugs:</b>	80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)	80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)
<b>Other</b>	<b>Preferred Provider</b>	<b>Out-of-Network</b>
<b>Ambulance:</b> <i>(includes ground and air transportation.)</i>	80% of Usual & Customary Charges/\$200 maximum	80% of Usual & Customary Charges/\$200 maximum
<b>Durable Medical Equipment:</b>	80% of Usual & Customary Charges	80% of Usual & Customary Charges
<b>Consultant:</b>	Preferred Allowance	Usual & Customary Charges
<b>Dental:</b> <i>(Injury to Sound, Natural Teeth only.)</i>	80% of Usual & Customary Charges/\$100 maximum per tooth/\$500 maximum (Per Policy Year)	80% of Usual & Customary Charges/\$100 maximum per tooth/\$500 maximum (Per Policy Year)
<b>Alcoholism/Drug Abuse:</b>	See Benefits for Treatment of Mental Illness, Emotional Disorders, and Drug and Alcohol Abuse	See Benefits for Treatment of Mental Illness, Emotional Disorders, and Drug and Alcohol Abuse
<b>Maternity:</b> <i>(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.)</i>	See Benefits for Maternity Expenses	See Benefits for Maternity Expenses
<b>Elective Abortion:</b>	Paid as any other Sickness/\$500 maximum (Per Policy Year)	Paid as any other Sickness/\$500 maximum (Per Policy Year)
<b>Complications of Pregnancy:</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Repatriation:</b>	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
<b>Medical Evacuation:</b>	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
<b>*AD&amp;D:</b>	See Endorsement	See Endorsement
<b>Intercollegiate Sports:</b>	No Benefits	No Benefits
<b>MRI/Cat Scan:</b>	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
<b>Child Health Assurance:</b> <i>(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.)</i>	Preferred Allowance	Usual & Customary Charges
<b>Cervical Cytology Screening:</b> <i>(Annual Cervical Cytology Screening for Cervical Cancer and its precursor states for women age 18 and older: The Cervical Cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.)</i>	Preferred Allowance	Usual & Customary Charges

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2006-201590-92**  
**INJURY AND SICKNESS BENEFITS**

**MAJOR MEDICAL**

**Maximum Benefit**

**No Benefits**

**CATASTROPHIC MEDICAL**

**Maximum Benefit**

**No Benefits**

**SHC Referral Required:** Yes ( ) No (X)    **Conversion Permitted:** Yes ( ) No (X)

**\*Pre-Admission Notification:** Yes (X) No ( )

(X) **Extension of Benefits**

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

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

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2006-201590-92**  
**INJURY AND SICKNESS BENEFITS**

**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 Maryland and Beech Street when outside of Maryland.

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.

“**Network Area**” means the 50 mile radius around the local school campus the Named Insured is attending.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. 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 80%, 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 Alliance in Maryland and Beech Street when outside of Maryland will be paid at 80% of the Preferred Allowance 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) for State of Maryland facilities, rate approved by Health Services Cost Review Commission (HSCRC); for all other areas, daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** If provided in 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; blood products, both derivatives and components, 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:** See Benefits for Maternity Expenses.
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 and Nurse Anesthetist Services:** professional services administered in connection with inpatient surgery.
9. **Registered Nurse:** 1) private duty nursing care only; 2) while Hospital Confined; and 3) ordered by a licensed Physician. General nursing care provided by the Hospital is not covered under this benefit.
10. **Physician's Visits:** when Hospital Confined. 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. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits and the Benefits for the Treatment of Mental Illness, Emotional Disorders and Alcohol and Drug Abuse.

## MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS (Continued)

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 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, including blood products, both derivatives and components, 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. **Psychotherapy (Outpatient):** the benefits and the maximum amounts are specified in the Schedule of Benefits, the Benefits for the Treatment of Mental Illness, Emotional Disorders and Alcohol and Drug Abuse and Benefits for Residential Crisis Services.
29. **Ambulance Services:** See Schedule of Benefits.

## MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS *(Continued)*

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. **Alcoholism/Drug Abuse Treatment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and the Benefits for the Treatment of Mental Illness, Emotional Disorders and Alcohol and Drug Abuse
34. **Maternity:** See Benefits for Maternity Expenses.
35. **Complications of Pregnancy:** Same as any other Sickness.
36. **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.
37. **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.
38. **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.
39. **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.
40. **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 HOME HEALTH CARE**

Benefits will be paid the same as any other Injury or Sickness for home health care services provided the: 1) Hospital or skilled nursing home confinement would otherwise have been required if home health care was not provided; and 2) the plan of treatment covering the home health care service is established and approved in writing by the Physician. Home health care must be provided by: 1) a person licensed under the Health Occupations Article or a home health aide; 2) a Hospital possessing a valid operating certificate, and certified to provide home health services; or, 3) a public or private health service or agency which is licensed as a home health agency pursuant to Title 19; Subtitle 4 of the Health General Article. Each visit by a member of a home care team is considered as one home care visit. Benefits will be limited to a maximum of 40 visits per policy year.

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

**BENEFITS FOR HOSPICE CARE**

Benefits for Hospice Care are limited to the benefits payable for Room and Board Expense or the benefits payable for Hospital Miscellaneous Expenses, whichever is less. Benefits will be paid for the following services provided by a Hospital, related institution, home health agency, hospice or other licensed facility under a Hospice Care Program. Such services must be a part of a Hospice Care Program for:

- (a) Inpatient care services;
- (b) Physician services; or
- (c) Home hospice care services.

Benefits for the above are limited as follows

- (a) Benefits are payable only if the terminally ill person is an Insured Person;
- (b) 30 days of inpatient care per Insured;
- (c) Part-time nursing care by or supervised by a registered graduate nurse;
- (d) Counseling, including dietary counseling, for the terminally ill Insured;
- (e) Family counseling for the immediate family or family caregiver before the death of the terminally ill Insured;
- (f) Bereavement counseling for the Insured Person's Immediate Family or family caregiver for at least the 6-month period following Insured's death or 15 visits, whichever occurs first;
- (g) Respite care is subject to the following:
  - (1) The annual benefit shall be 14 days, and
  - (2) Any one inpatient stay is limited to 5 consecutive days.
- (h) Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Insured.

The following definitions apply to this section only.

"Hospice Care Program" means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual and social needs of terminally ill Insured Persons and their Immediate Families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement:

- (a) to individuals who have no reasonable prospect of cure and, as estimated by a Physician, have a life expectancy of less than six months; and
- (b) to the Immediate Families or family caregivers of those individuals.

"Immediate family" means the spouse, parents, siblings, grandparents, and children of the terminally ill Insured.

Benefits are not payable under this part for expense incurred on or after the Medicare Eligibility Date.

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

## **BENEFITS FOR MATERNITY EXPENSES**

Benefits will be paid for normal pregnancy and normal childbirth as for any other Sickness subject to the following:

Benefits will be paid for a mother and newborn child for a minimum of:

- 1) 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and
- 2) 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

When the mother remains hospitalized for medical reasons beyond the minimum time specified above, newborn care will be provided for an additional 4 days of Hospital confinement.

If prescribed by the Physician, one Home Visit will be provided for a mother and her newborn child who remain in the Hospital for the above referenced lengths of time.

If the decision is made between the mother and the Physician for a shorter Hospital stay, then benefits will be provided for one Home Visit scheduled to occur within 24 hours after the Hospital discharge and one additional Home Visit if prescribed by the Physician.

“Home visit” shall:

- 1) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
- 2) be provided by a Registered Nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
- 3) include any services required by the Physician.

With regard to this section only, Home Visits are not subject to any copayment, coinsurance or Deductible. Benefits will be provided even if the services do not occur within the time specified.

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

## **BENEFITS FOR IN VITRO FERTILIZATION**

Benefits will be paid for outpatient expenses arising from in vitro fertilization to the same extent as benefits provided for other pregnancy related procedures.

Benefits shall apply if:

- 1) The patient is the Named Insured or a covered Dependent spouse of the Named Insured;
- 2) The Insured's oocytes are fertilized with the Insured's spouse's sperm;
- 3) The Insured and the Insured's spouse have a history of infertility of at least 2 years duration;
- 4) The infertility is associated with any of the following medical conditions:
  - a. endometriosis;
  - b. exposure in utero to diethylstilbestrol, commonly known as DES;
  - c. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
  - d. abnormal male factors, including oligospermia, contributing to the infertility;
- 5) The Insured has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy.
- 6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

This benefit will be limited to three (3) in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.

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 screening mammography to identify breast cancer in an Insured according to the following guidelines:

- 1) A baseline Mammogram for an Insured age 35 to 39;
- 2) A Mammogram for an Insured age 40 to 49 every 2 years, or more frequently if recommended by a Physician; and
- 3) An annual Mammogram for an Insured age 50 and over.

"Mammogram" means x-ray examination of the breast using dedicated equipment, including x-ray tube, filter, compression device, screens, films, and cassettes, specifically for mammography with average radiation exposure to deliver less than 1 rad mid-breast, 2 views per breast.

Such screening must be provided in facilities accredited by the American College of Radiology or certified or licensed under a program established by the state of Maryland.

Benefits shall not be subject to the Deductible, but are subject to all copayment, coinsurance, limitations or any other provisions of the policy.

### **BENEFITS FOR POST-MASTECTOMY**

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery or prosthesis following a Mastectomy. Benefits shall include: 1) reconstruction of the breast on which the Mastectomy has been performed; 2) surgery and reconstruction of the nondiseased breast to establish symmetry; and 3) prosthesis and physical complications from all stages of the Mastectomy, including lymphedemas.

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

"Reconstructive breast surgery" means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

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

### **BENEFITS FOR HOME VISITS FOLLOWING MASTECTOMY OR TESTECTOMY/ORCHIECTOMY**

Benefits will be paid the same as any other Sickness for one home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility for an Insured Person who receives less than 48 hours of inpatient hospitalization following a mastectomy or a testectomy/orchiectomy or if the procedure is done on an outpatient basis. The Insured Person may receive an additional home visit if prescribed by their Physician.

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

### **BENEFITS FOR CHLAMYDIA AND HUMAN PAPILLOMAVIRUS SCREENING TESTS**

Benefits will be paid the same as any other Sickness for the following screening tests for Insured Persons:

- 1) One annual routine Chlamydia Screening Test for:
  - a) Women who are under the age of 20 years if they are sexually active, and at least 20 years old if they have multiple risk factors; and
  - b) Men who have Multiple Risk Factors

"Chlamydia screening test" means any laboratory test that:

- a) Specifically detects for infection by one or more agents of chlamydia trachomatis; and
- b) Is approved for this purpose by the federal Food and Drug Administration.

"Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

**BENEFITS FOR CHLAMYDIA AND HUMAN PAPILLOMAVIRUS SCREENING TESTS**  
(Continued)

- 2) Human Papillomavirus Screening Test at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

“Human papillomavirus screening test” means any laboratory test that:

- a) Specifically detects for infection by one or more agents of the human papillomavirus; and
- b) Is approved for this purpose by the Federal Food and Drug Administration.

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

**BENEFITS FOR NICOTINE REPLACEMENT THERAPY DRUGS**

Benefits will be paid under the Prescription Drug Benefit for two 90-day courses of Nicotine Replacement Therapy per policy year.

“Nicotine replacement therapy” means a product that:

- 1) Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and
- 2) Is obtained under a prescription written by an authorized prescriber.

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 in accordance with the latest screening guidelines issued by the American Cancer Society (ACS).

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 for the expenses incurred in conducting a diagnostic examination which shall include a digital rectal exam and a prostate-specific antigen (PSA) test:

- 1) for men between the ages of 40 and 75;
- 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
- 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or
- 4) when used for men who are at high risk for prostate cancer.

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

**BENEFITS FOR PRESCRIPTION CONTRACEPTIVES**

Benefits will be paid the same as any other Sickness for any contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid for the insertion or removal and any medical examination associated with the use of such contraceptive drug or device.

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

## **BENEFITS FOR OSTEOPOROSIS PREVENTION AND TREATMENT**

Benefits will be paid the same as any other Sickness for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis when the Bone Mass Measurement is requested by a Physician for a Qualified Individual.

“Bone mass measurement” means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.

“Qualified individual” means: 1) an estrogen deficient individual at clinical risk for osteoporosis; 2) an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; 3) an individual receiving long term glucocorticoid (steroid) therapy; 4) an individual with primary hyperparathyroidism; or 5) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

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

## **BENEFITS FOR MORBID OBESITY**

Benefits will be paid the same as any other surgery for surgical treatment of Morbid Obesity that is recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with criteria approved by the National Institutes of Health.

“Body mass index” means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

“Morbid obesity” means a Body Mass Index that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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

## **BENEFITS FOR HAIR PROSTHESES FOR HAIR LOSS RESULTING FROM CHEMOTHERAPY OR RADIATION TREATMENT FOR CANCER**

Benefits will be paid for one hair prosthesis when prescribed by a Physician for an Insured whose hair loss results from chemotherapy or radiation treatment for cancer. The benefit will be limited to \$350.00.

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

## **BENEFITS FOR CLINICAL TRIAL COSTS**

Benefits will be paid the same as any other Sickness for Patient Costs to an Insured in a clinical trial, as a result of:

- 1) treatment provided for a life-threatening condition; or
- 2) prevention, early detection, and treatment studies on cancer.

These benefits will be provided only if:

- 1) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or for any other life-threatening condition;
- 2) the treatment is being provided in a clinical trial approved by:
  - a) one of the National Institutes of Health (NIH);
  - b) an NIH cooperative group or an NIH center;
  - c) the FDA in the form of an investigational new drug application;
  - d) the federal Department of Veterans Affairs; or
  - e) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health.
- 3) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- 4) there is no clearly superior, noninvestigational treatment alternative; and

- 5) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Benefits will be paid for Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

"Patient cost" means the cost of a health care service that is incurred as a result of the treatment being provided to the Insured for purposes of the clinical trial.

Patient cost does not include:

- 1) the cost of an investigational drug or device;
- 2) 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 the clinical trial;
- 3) costs associated with managing the research associated with the clinical trial; or
- 4) costs that are not covered under this policy for noninvestigational treatments.

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

### **BENEFITS FOR RESIDENTIAL CRISIS SERVICES**

Benefits will be paid the same as any other Sickness for Residential Crisis Services for treatment of mental illness.

"Residential Crisis Services" means intensive mental health and support services that are:

- a) Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the Insured's ability to function in the community;
- b) Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
- c) Provided out of the Insured's residence on a short-term basis in a community-based residential setting; and
- d) Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide Residential Crisis Services.

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

### **BENEFITS FOR TREATMENT OF MENTAL ILLNESS, EMOTIONAL DISORDERS, AND DRUG AND ALCOHOL ABUSE**

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder as specified below.

#### **Inpatient Benefits**

Inpatient benefits will be paid the same as any other Sickness for services provided in a Hospital.

#### **Partial Hospitalization Benefits**

A maximum of 60 days of Partial Hospitalization are covered the same as any other Sickness.

"Partial hospitalization" means the provision of medically directed intensive or intermediate short-term treatment:

- a) to an Insured;
- b) in a licensed or certified facility or program;
- c) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and
- d) for a period of less than 24 hours but more than 4 hours in a day.

#### **Outpatient Benefits**

Outpatient benefits, including psychological and neuropsychological testing for diagnostic purposes, other than for Inpatient or Partial Hospitalization, will be paid the same as any other Sickness subject to the coinsurance limitations stated below.

- 1) 80% for the first five visits in a policy year;
- 2) 65% for the 6<sup>th</sup> through 30<sup>th</sup> visit in a policy year;
- 3) 50% for the 31<sup>st</sup> visit and any subsequent visit in a policy year.

Medication management visits are payable as any other Sickness and are not counted against the number of visits stated above. The company will pay 50% of the daily cost of methadone management treatment.

**BENEFITS FOR TREATMENT OF MENTAL ILLNESS, EMOTIONAL DISORDERS, AND  
DRUG AND ALCOHOL ABUSE (Continued)**

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

**BENEFITS FOR TREATMENT OF DIABETES**

Benefits will be paid the same as any other Sickness for all equipment, supplies and diabetes outpatient self-management training and educational services, including medical nutrition therapy, when the Insured's treating Physician or a Physician who specializes in the treatment of diabetes, or other appropriate licensed health care provider certifies that such services are for the treatment of: 1) insulin-using diabetes; 2) noninsulin-using diabetes; or 3) elevated blood glucose levels induced by pregnancy.

If certified by the treating Physician, the diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided to the Insured through a program supervised by a Physician or an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

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

**BENEFITS FOR MEDICAL FOODS AND MODIFIED FOOD PRODUCTS**

Benefits will be paid the same as any other Sickness for Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases of a covered Dependent child if the Medical Foods or Low Protein Modified Food Products are:

- 1) Prescribed for the therapeutic treatment of inherited metabolic diseases; and
- 2) Administered under the direction of a Physician.

“Inherited metabolic disease” means a disease caused by an inherited abnormality of body chemistry and includes a disease for which the State screens newborn babies.

“Low protein modified food product” means a food product that is:

- 1) Specially formulated to have less than 1 gram of protein per serving; and
- 2) Intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Low protein modified food product does not include a natural food that is naturally low in protein.

“Medical food” means a food that is:

- 1) Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
- 2) Formulated to be consumed or administered enterally under the direction of a Physician.

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

**BENEFITS FOR ANESTHESIA FOR DENTAL CARE**

Benefits will be paid the same as any other Sickness for general anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to an Insured that is:

- 1) 7 years of age or younger or is developmentally disabled;
- 2) an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Insured;
- 3) an individual for whom a superior result can be expected from dental care provided under general anesthesia; or
- 4) an extremely uncooperative, fearful, or uncommunicative child who is 17 years or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
- 5) an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

These benefits must be provided by one of the following:

- 1) a fully accredited specialist in pediatric dentistry;

### **BENEFITS FOR ANESTHESIA FOR DENTAL CARE (Continued)**

- 2) a fully accredited specialist in oral and maxillofacial surgery; or
- 3) a dentist to whom Hospital privileges have been granted.

This benefit does not cover charges for the dental care itself, only the charges for the general anesthesia or associated Hospital or ambulatory facility charges, nor does it apply to dental care rendered for temporal mandibular joint disorder (TMJ).

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

### **BENEFITS FOR TREATMENT OF CLEFT LIP AND CLEFT PALATE**

Benefits will be paid the same as any other Sickness for inpatient or Outpatient expenses arising from orthodontics; oral surgery; otologic; audiological and speech/language treatment involved in the management of birth defects known as cleft lip and cleft palate or both.

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

### **BENEFITS FOR HABILITATIVE SERVICES FOR CHILDREN**

Benefits will be paid the same as any other Sickness for Habilitative Services for the Named Insured and Insured Dependents under the age of 19 years. Benefits will not be paid for Habilitative Services delivered through early intervention or school services.

"Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the child's ability to function.

"Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

This benefit is not subject to the limits for physical therapy, speech therapy, or occupational therapy, but is subject to all Deductible, copayments, coinsurance, or any other provisions of the policy.

### **BENEFITS FOR CHILD WELLNESS**

Benefits will be paid for the following Child Wellness Services for a covered Dependent child:

- 1) All Physician's visits for and Covered Medical Expenses incurred for: a) childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control; b) collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age; and c) age-appropriate screening tests for tuberculosis; anemia; lead toxicity; hearing; and vision as determined by the American Academy of Pediatrics; and
- 2) Universal hearing screening of newborns provided by a Hospital before discharge.

The following services at each of the Physician's visits described above are included:

- 1) A physical examination;
- 2) A developmental assessment;
- 3) Parental anticipatory guidance; and,
- 4) The requisite laboratory tests.

"Child wellness services" means a preventive activity designed to: 1) protect children from morbidity and mortality; and 2) promote child development. Such activities must be in keeping with: 1) prevailing medical standards; 2) public health policy; and 3) scientific evidence of effectiveness.

Benefits shall not be subject to the Deductible, but are subject to copayments, coinsurance, limitations or any other provisions of the policy.

### **BENEFITS FOR MINOR DEPENDENT HEARING AID**

Benefits will be paid the same as any other Sickness for Hearing Aids for a minor Dependent child if the Hearing Aids are prescribed, fitted, and dispensed by a licensed audiologist. Benefits will not exceed \$1,400 per Hearing Aid for each hearing-impaired ear every 36 months.

“Hearing Aid” means a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children and is nondisposable.

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, except as specifically provided in the Benefits for Nicotine Replacement Therapy Drugs, 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: 1) Newborn and Adopted Infants; or 2) under the Benefits for Habilitative Services; or 3) Benefits for Treatment of Cleft Lip and Cleft Palate;
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 or as specifically provided in Benefits for Anesthesia for Dental Care;
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 due to a 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. Loss scheduled in the Optional Accidental Death and Dismemberment benefit sustained in consequence of the Insured's being intoxicated or under the influence of any narcotic, or any drugs 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 as specifically provided in Benefits for Habilitative Services for Children or; 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;

## **EXCLUSIONS AND LIMITATIONS (Continued)**

18. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of Creditable Coverage that was continuous to within 63 days prior to the Insured's Effective Date under this policy.
19. 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. Immunization agents, biological sera;
  - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for Phase I, II, III or IV clinical trials for cancer, AIDS or other life-threatening conditions;
  - d. Products used for cosmetic purposes;
  - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
  - f. Anorectics - drugs used for the purpose of weight control;
  - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra, except as specifically provided in the policy;
  - h. Growth hormones; or
  - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
20. Reproductive/Infertility services including but not limited to: family planning, premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in the policy;
21. 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 policy;
22. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the policy;
23. 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;
24. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
25. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
26. 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;
27. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment, except for institutions or Hospitals of the State of Maryland or any county or municipality thereof, whether such institutions or Hospital be deemed charitable, or otherwise;
30. 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
31. Except as specifically provided in Benefits for Morbid Obesity, 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, except as specifically provided in the policy. 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 whose benefits must be determined without taking the existence of any other plan into consideration.
- (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.

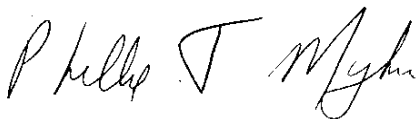
**COORDINATION OF BENEFITS PROVISION (Continued)**

- (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.

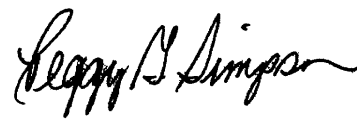
**Right to Recovery and Release of Necessary Information** - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to 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.



**President**



**Secretary**

**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 pay the applicable amount below in addition to payment under the "Medical Expense Benefits" (and under Major Medical, if coverage is afforded under Major Medical) provision.

#### 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 to any one Insured Person.

Extension of Benefits After Termination: The coverage provided under this benefit ceases on the Termination Date. However, if the loss results from an Injury that occurred while the Insured was covered under this policy, benefits will be paid for such loss provided the loss occurs within 90 days after the date of such Injury.



President



Secretary

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.

# 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 calling 1-877-295-0720.

**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.

