

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:*

Florida Preferred Provider is SouthCare	(201596-92)
Maine Preferred Provider is PHCS	(201589-92)
Maryland Preferred Provider is Alliance	(201590-92)
New York Preferred Provider is MultiPlan	(201593-92)
North Carolina Preferred Provider is MedCost	(201594-92)
Pennsylvania Preferred Provider is Devon	(201595-92)
Virginia 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 Benefit	13
Exclusions and Limitations	17

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 agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

STATEMENTS IN APPLICATIONS: All statements made by the Policyholder shall be deemed representations and not warranties.

GENERAL PROVISIONS (Continued)

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

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

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.

CLAIM FORMS: Claim forms are not required.

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

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

PAYMENT OF CLAIMS: If the Named Insured requests in writing not later than the time of filing proofs of such loss, all or a portion of any indemnities provided by this policy will be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. 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: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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

SUBROGATION: The Company may have a right 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. The Company may not exercise this right of recovery without the prior written consent of the Insured. Allowances will be made for legal fees, court costs and compromise settlements.

GENERAL PROVISIONS (Continued)

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.

GUARANTEED RENEWABILITY: This policy is guaranteed renewable for the policyholder and Insureds except (a) when the policyholder fails to pay premiums in accordance with the terms of the policy; (b) for fraud or intentional misrepresentation of material fact by the policyholder; (c) for fraud or intentional misrepresentation of material fact on the part of the Insured or Insured's representative; or (d) when the Insured no longer meets the Eligibility requirements of the policy.

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 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.

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

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

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

DEFINITIONS *(Continued)*

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS (Continued)

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

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

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

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

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

MEDICAL NECESSITY means health care services or products provided to an Insured for the purpose of preventing, diagnosing or treating an Injury or Sickness or the symptoms of an Injury or Sickness in a manner that is:

- 1) Consistent with generally accepted standards of medical practice;
- 2) Clinically appropriate in terms of type, frequency, extent, site and duration;
- 3) Demonstrated through scientific evidence to be effective in improving health outcomes;
- 4) Representative of "best practices" in the medical profession; and,
- 5) Not primarily for the convenience of the Insured, or the Insured's Physician.

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

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

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

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

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

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 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.

DEFINITIONS *(Continued)*

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

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

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

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

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 6 months immediately prior to the Insured's Effective Date under the policy.

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

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

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

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

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

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. 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 reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. The Insured may be billed for any charges which exceed the Usual and Customary Charges. The Insured may call the Company at 1-800-767-0700 for the maximum Usual and Customary Charge for a specified service.

PART IV

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured incurs medical expenses within 6 months of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues:

- 1) When not Totally Disabled on the Termination Date, not to exceed 30 days after the Termination Date; or
- 2) When Totally Disabled on the Termination Date, not to exceed 6 months after the Termination Date.

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

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

**PART IV
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN
2006-201589-92
INJURY AND SICKNESS BENEFITS**

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

The Preferred Providers for this plan are members of PHCS.

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

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.

Inpatient	Preferred Provider	Out-of-Network
Room & Board / Hospital Misc.:	Preferred Allowance/\$100 co-pay per day for 1 st 3 days	Usual & Customary Charges/\$100 Deductible per day for 1 st 3 days
Intensive Care:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Routine Newborn Care:	Paid as any other Sickness/4 days maximum	Paid as any other Sickness/4 days maximum
Physiotherapy: (<i>\$2,500 maximum total for Inpatient and Outpatient combined.</i>)	Preferred Allowance/\$2,500 maximum	Usual & Customary Charges/\$2,500 maximum
Surgery: (<i>Specified surgery based on data provided by Ingenix.</i>)	Preferred Allowance	Usual & Customary Charges
Assistant Surgeon:	Paid under Surgery	Paid under Surgery
Anesthetist:	Paid under Surgery	Paid under Surgery
Registered Nurse's Services:	Preferred Allowance	Usual & Customary Charges
Physician's Visits:	Preferred Allowance	Usual & Customary Charges
Pre-admission Testing:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Psychotherapy:	See Benefits for Mental Illness	See Benefits for Mental Illness
Outpatient	Preferred Provider	Out-of-Network
Surgery: (<i>Specified surgery based on data provided by Ingenix.</i>)	Preferred Allowance	Usual & Customary Charges
Day Surgery Miscellaneous: (<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
Assistant Surgeon:	Paid under Surgery	Paid under Surgery
Anesthetist:	Paid under Surgery	Paid under Surgery
Physician's Visits:	Preferred Allowance/\$20 co-pay per visit	Usual & Customary Charges/\$20 Deductible per visit

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN
2006-201589-92
INJURY AND SICKNESS BENEFITS

Outpatient (Continued)	Preferred Provider	Out-of-Network
Physiotherapy:	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>		
Outpatient Misc. Benefits:	No Benefits	No Benefits
Medical Emergency:	Preferred Allowance/\$150 co-pay per visit	80% of Usual & Customary Charges/\$150 Deductible per visit
X-rays & Laboratory:	Preferred Allowance/\$20 co-pay per test	Usual & Customary Charges/\$20 Deductible per test
Radiation Therapy/Chemotherapy:	Preferred Allowance/\$1,000 maximum	Usual & Customary Charges/\$1,000 maximum
Tests & Procedures:	Preferred Allowance/\$20 co-pay per test	Usual & Customary Charges/\$20 Deductible per test
Psychotherapy:	See Benefits for Mental Illness	See Benefits for Mental Illness
Prescription Drugs:	80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)	80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)
Other		
Ambulance: <i>(includes ground and air transportation.)</i>	80% of Usual & Customary Charges/\$200 maximum	80% of Usual & Customary Charges/\$200 maximum
Durable Medical Equipment:	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Consultant:	Preferred Allowance	Usual & Customary Charges
Dental: <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)
Maternity: <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>	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	Paid as any other Sickness/\$500 maximum (Per Policy Year)	Paid as any other Sickness/\$500 maximum (Per Policy Year)
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Alcoholism/Drug Dependency:	See Benefits for Mental Illness	See Benefits for Mental Illness
Repatriation:	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
Medical Evacuation:	Benefits provided by Assist America, Inc.	Benefits provided by Assist America, Inc.
*AD&D:	See Endorsement	See Endorsement
Intercollegiate Sports:	No Benefits	No Benefits
MRI/Cat Scan:	Preferred Allowance/\$1,200 maximum (Per Policy Year)/\$100 co-pay per test	Usual & Customary Charges/\$1,200 maximum (Per Policy Year)/\$100 Deductible per test
Child Health Assurance: <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

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN
2006-201589-92
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 ()

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

Other Insurance: (X) ***Coordination of Benefits** () **Primary Insurance** (X) **Excess Motor Vehicle Only**

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

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN
2006-201589-92
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 PHCS.

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

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

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

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

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at 80% of the Preferred Allowance, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Preferred Providers will be paid at 80% of the Preferred Allowance or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

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

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

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** 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; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. The benefits and the maximum amounts are specified in the Schedule of Benefits. No deductible is applied for benefits provided for the newborn baby. Newborn care does not include any services provided after the mother has been discharged from the Hospital.
5. **Physiotherapy (Inpatient):** See Schedule of Benefits.
6. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.
7. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
8. **Anesthetist Services:** professional services administered in connection with inpatient surgery.
9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
10. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
12. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Benefits For Mental Illness.

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 are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.
19. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.
20. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
21. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
22. **Radiation Therapy (Outpatient):** See Schedule of Benefits.
23. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
24. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
25. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
26. **Chemotherapy (Outpatient):** See Schedule of Benefits.
27. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
28. **Psychotherapy (Outpatient)** the benefits and the maximum amounts are specified in the Benefits For Mental Illness.
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 Dependency:** the benefits and the maximum amounts are specified in the Benefits For Mental Illness.
34. **Maternity:** Same as any other Sickness.
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 ANNUAL GYNECOLOGICAL EXAMINATION AND PAP TEST

Benefits will be paid the same as any other Sickness for an annual gynecological examination including routine pelvic and clinical breast examinations. Benefits will also be paid the same as any other Sickness for screening Pap tests recommended by a Physician.

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

BENEFITS FOR BREAST CANCER TREATMENT AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for breast cancer treatment and post-mastectomy reconstruction.

Coverage for the treatment of breast cancer shall be provided for a period of time determined by the attending Physician, in consultation with the patient, to be Medically Necessary following a mastectomy, a lumpectomy or a lymph node dissection.

Post mastectomy reconstruction includes the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the Insured elects reconstruction and in the manner chosen by the Insured and the Physician.

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

BENEFITS FOR MAMMOGRAM

Benefits will be paid the same as any other Sickness for screening mammograms performed by Physicians that meet the standards established by the Department of Human Services rules relating to radiation protection. Benefits will be provided for screening mammograms performed at least once a year for Insureds 40 years of age and over.

Benefits shall be subject to all Deductibles, 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 Services For The Early Detection of Prostate Cancer. Services for the early detection of prostate cancer means the following procedures provided to a man for the purpose of early detection of prostate cancer: (a) a digital rectal examination; and (b) a prostate-specific antigen test. Benefits shall be provided for services for the early detection of prostate cancer, if recommended by a Physician, at least once a year for Insureds 50 years of age or older until an Insured reaches the age of 72.

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

BENEFITS FOR CHIROPRACTIC SERVICES

Benefits will be paid the same as any other Sickness for services performed by a chiropractor to the extent that services are within the lawful scope of practice of a chiropractor licensed to practice in Maine. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

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

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the Medically Necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: (1) the Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and (2) the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

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

MANDATED BENEFITS (Continued)

BENEFITS FOR MODIFIED LOW-PROTEIN FOOD PRODUCT

Benefits will be paid the same as any other Sickness for metabolic formula and Special Modified Low-Protein Food Products that have been prescribed by a licensed Physician for a person with an Inborn Error of Metabolism. Benefits shall be provided for metabolic formula and not to exceed \$3,000.00 per policy year for Special Modified Low-Protein Food Products.

Inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

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

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid the same as any other Prescription Drugs or outpatient medical services for all prescription contraceptives approved by the federal Food and Drug Administration or for Outpatient Contraceptive Services.

“Outpatient contraceptive services” means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. The benefit may not be construed to apply to Prescription Drugs or devices that are designed to terminate a pregnancy.

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

BENEFITS FOR MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for Mental Illness, Alcoholism and Drug Dependency.

Benefits for an Insured suffering from Mental Illness include the following: Inpatient care; Day treatment services; Outpatient services; Home health care services.

Mental illness shall include the following categories as defined in the Diagnostic and Statistical Manual, except for those that are designated as “V” codes by the Diagnostic and Statistical Manual:

- (1) Psychotic disorders, including schizophrenia
- (2) Dissociative disorders;
- (3) Mood disorders;
- (4) Anxiety disorders;
- (5) Personality disorders;
- (6) Paraphilias
- (7) Attention deficit and disruptive behavior disorders;
- (8) Pervasive development disorders;
- (9) Tic disorders;
- (10) Eating disorders, including bulimia and anorexia; and
- (11) Substance abuse-related disorders.

Amounts payable for specific inpatient services are limited by the Schedule of Benefits. All outpatient expenses incurred for other or ancillary services stated on the Schedule of Benefits; and incurred as a result of Alcoholism and Drug Dependency are subject to the above aggregate maximums.

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

MANDATED BENEFITS (Continued)

BENEFITS FOR CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Costs in connection with participation in an Approved Clinical Trial.

Qualified Insured: An Insured is eligible for coverage for participation in an Approved Clinical Trial if the Insured meets the following conditions:

- A. The Insured has a life-threatening Sickness for which no standard treatment is effective;
- B. The Insured is eligible to participate according to the clinical trial protocol with respect to treatment of such Sickness;
- C. The Insured's participation in the trial offers meaningful potential for significant clinical benefit to the Insured; and
- D. The Insured's referring Physician has concluded that the Insured's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

"Approved clinical trial," means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

"Routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

In the case of Covered Medical Expenses, the Company shall pay Participating Providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by Participating Providers.

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

BENEFITS FOR HOSPICE CARE SERVICES

Benefits will be paid the same as any Sickness for Hospice Care Services to an Insured who is Terminally Ill.

Hospice Care Services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of Hospice Care Services. Coverage for Hospice Care Services will be provided whether the services are provided in a home setting or an inpatient setting.

"Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to an Insured who is terminally ill and that Insured's family. Hospice care services includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

"Terminally ill" means an Insured that has a medical prognosis that the life expectancy is 12 months or less if the Sickness runs its normal course.

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

BENEFITS FOR GENERAL ANESTHESIA FOR DENTISTRY

Benefits will be paid the same as any Sickness for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of an Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital.

MANDATED BENEFITS (Continued)

This section applies only to general anesthesia and associated facility charges for only the following Insureds:

- A. Insureds, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
- B. Insureds demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and
- D. Insureds who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

This does not include benefits for any charges for the dental procedure itself, other than specifically provided for in the Schedule of Benefits, including, but not limited to, the professional fee of the dentist.

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

BENEFITS FOR PROSTHETIC DEVICES

Benefits will be paid the same as any Sickness for Prosthetic Devices determined by the Insured's Physician to be the most appropriate model that adequately meets the medical needs of the Insured. Benefits will include repair and replacement of a Prosthetic Device if the Insured's Physician determines such repair or replacement appropriate.

Prosthetic Device means an artificial device to replace, in whole or in part, an arm or a leg.

No coverage will be provided for a Prosthetic Device that contains a microprocessor or that is designed exclusively for athletic purposes.

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

BENEFITS FOR OFF-LABEL DRUG USE

Benefits will be paid the same as any other Prescription Drug, including medically necessary services associated with the administration of such drugs, for the Off-Label Use of Prescription Drugs for the treatment of cancer or HIV/AIDS.

Benefits will not be denied for Prescription Drugs under this provision based on Medical Necessity, unless such denial is unrelated to the legal status of the drug's use. Benefits will not be paid for Prescription Drugs under this provision where the use is contraindicated by the federal Food and Drug Administration.

"Off-Label Use" means the use of a federal Food and Drug Administration approved drug. The drug need not have been approved for the treatment of cancer or of HIV/AIDS if the use of such drug is supported by one or more citations in (a) the United States Pharmacopeia Drug Information or its successors; (b) the American Hospital Formulary Service Drug Information or its successors; or (c) Peer-reviewed Medical Literature.

"Peer-reviewed Medical Literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals. These articles must present evidence that supports the Off-Label Use as generally safe and effective.

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

**PART VIII
EXCLUSIONS AND LIMITATIONS**

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

1. Acne; acupuncture;
2. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Biofeedback;
4. Injections;
5. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
7. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
9. Elective Surgery or Elective Treatment;
10. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when 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;
13. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
16. Injury sustained while (a) participating in any interscholastic, high school, intramural, club, or 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;

EXCLUSIONS AND LIMITATIONS (Continued)

17. Organ transplants, including organ donation;
18. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
19. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
20. Pre-existing Conditions, except for individuals who have been continuously insured under the International Community Service 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 continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
21. 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, blood or blood products administered on an outpatient basis;
 - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the Benefits for Off-Label Drug Use;
 - 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;
 - h) Growth hormones; or
 - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
22. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
23. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Benefits For Clinical Trails;
24. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
25. 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;
26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
27. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
28. 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;
29. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

EXCLUSIONS AND LIMITATIONS (Continued)

31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
32. 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
33. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

POLICY ENDORSEMENT

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

COORDINATION OF BENEFITS PROVISION

Definitions

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

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

- (2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage for which the parent pays the entire premium; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.
- (3) **Primary:** The Plan which pays regular benefits.
- (4) **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.
- (5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

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

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

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

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

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

- (1) If the Insured's other Plan does not have Coordination of Benefits, that Plan pays first.
- (2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

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.

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

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

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

For Loss Of:

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

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

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

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:

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.

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:

UTILIZATION REVIEW, GRIEVANCE, AND EXTERNAL REVIEW PROCEDURES

The Utilization Review, Grievance and External Review Procedures apply to all Adverse Determinations and Adverse Health Care Treatment Decisions.

DEFINITIONS

For the purposes of this endorsement:

Adverse Determination or Adverse Health Care Treatment Decision means a health care treatment decision made by or on behalf of the Company offering a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an Insured. Health care treatment decision means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:

1. the Company's decisions, policies or actions related to availability, delivery or quality of health care services;
2. claims payment, handling or reimbursement for health care services;
3. the contractual relationship between an Insured Person and the Company; or
4. the outcome of an Adverse Determination.

UTILIZATION REVIEW PROCEDURES

1. Procedures for Review Decisions

- a. For initial determinations, the Company shall make the determination and notify the Insured and their provider within 2 working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination.
- b. For concurrent review determinations, the Company shall make the determination within one working day of obtaining all necessary information.
 - i. In the case of a determination to certify an extended stay or additional services, the Company shall notify the Insured and their provider within one working day. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
 - ii. In the case of an Adverse Determination, the Company shall notify the Insured and their provider within one working day. The service shall be continued without liability to the Insured until the Insured has been notified of the determination.
- c. For retrospective review determinations, the Company shall make the determination within 30 working days of receiving all necessary information.
 - i. In the case of a certification, the Company may notify in writing the Insured and their provider.
 - ii. In the case of an Adverse Determination, the Company shall within 5 working days of making the Adverse Determination notify in writing the provider and the Insured. The Company shall not without adequate written notice to the Insured prior to his or her receipt of previously authorized services render an Adverse Decision with regard to health care services authorized pursuant to prospective review, except where fraudulent or materially incorrect information was provided the Company at the time prior approval was granted, and the information was relied upon by the Company in rendering its approval.

A written notification of an Adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal for reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. The notification will include the telephone number the Insured may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria. The Company shall respond expeditiously to such written requests.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES (continued)

2. Requests for Reconsideration

- a. In a case involving an initial determination or a concurrent review determination, the Company shall give the provider an opportunity to request by telephone, fax or in writing on behalf of the Insured a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.
- b. The reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider and the reviewer who made the Adverse Determination or a clinical peer designated by the reviewer if the reviewer who made the Adverse Determination cannot be available within one working day.
- c. If the reconsideration process does not resolve the difference of opinion, the Adverse Determination may be appealed by the Insured or the provider on behalf of the Insured. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

3. Appeals of Adverse Determinations

a. Standard Appeals

- i. The Company shall notify in writing both the Insured or the Insured's representative and their provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where the Company can establish the 20 day time frame cannot reasonably be met due to the Company's inability to obtain necessary information from a person or entity not affiliated with or under contract with the Company. The Company shall provide written notice of the delay to the Insured or their representative and the provider. The notice shall explain the reasons for the delay. In such instances, a decision must be issued within 20 days of the Company's receipt of all necessary information.
- ii. An Adverse Decision shall contain:
 1. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
 2. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal;
 3. the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the Insured to respond further to the Company's position;
 4. a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision shall include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to the Insured. Where an Insured or their representative had previously submitted a written request for the clinical review criteria relied upon by the Company in rendering its initial Adverse Determination, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.
 5. the notice will advise of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.

b. Expedited Appeals

- i. Expedited Appeals shall be evaluated by an appropriate clinical peer or peers. The clinical peer shall not have been involved in the initial Adverse Determination.
- ii. Expedited review shall be available to all requests concerning an admission, availability of care, continued stay or health care service for an Insured who has received emergency services but has not been discharged from a facility.
- iii. The Company shall provide the Insured and the provider acting on behalf of the Insured all necessary information, including the Company's decision, by telephone, facsimile, electronic means or the most expeditious method available.
- iv. The Company shall make a decision and notify the Insured or the provider acting on behalf of the Insured via telephone as expeditiously as the Insured's medical condition requires, but in no event more than 72 hours after the review is initiated. If the expedited review is a concurrent review determination of emergency services or of an initially authorized admission or course of treatment, the service shall be continued without liability to the Insured until the Insured has been notified of the determination.
- v. If the initial notification was not in writing, the Company shall provide written confirmation of its decision concerning an expedited review within 2 working days of providing notification of that decision.
- vi. An expedited review is not available for retrospective Adverse Determinations.

4. Emergency Services

- a. The Company shall cover Medical Emergencies necessary to screen and stabilize an Insured and shall not require prior authorization of such services.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

- b. If the Company authorizes emergency services, the Company shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on fraudulent or materially incorrect information.

GRIEVANCE PROCEDURES

1. **First Level Review.** Except for an Adverse Determination, an Insured Person, or his or her provider may submit a written Grievance to the Company for review. First Level Review of an Adverse Determination is subject to Section 3 above, Appeals of Adverse Determinations.

The Insured Person will not be allowed to attend, or have a representative attend, a First Level Review. However, the Insured Person may submit written material for the review. Within 3 working days of the receipt of the Grievance by the Company, the Company shall provide the Insured the name, address and telephone number of the person who will coordinate the Grievance review.

The Company shall issue a written decision to the Insured Person and, if applicable, to the provider within 20 days after receiving the Grievance. Additional time is permitted where the Company can establish the 20 day time frame cannot reasonably be met due to the Company's inability to obtain necessary information from a person or entity not affiliated with or under contract with the Company. The Company shall provide written notice of the delay to the Insured or their representative and the provider explaining the reasons for the delay. In such instances, decisions must be issued within 20 days of the Company's receipt of all necessary information. The person reviewing the Grievance shall not be the same person who made the initial determination that initiated the Grievance.

- i. The written decision shall contain:
 1. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
 2. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal;
 3. the reviewers' decision in clear terms and the basis of the decision in sufficient detail for the Insured to respond further to the Company's position;
 4. a reference to the evidence or documentation used as the basis for the decision;
 5. notice of the availability of the Superintendent's office for assistance, including the telephone number and address of the Bureau of Insurance.
 6. notice advising of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.
2. **Second Level Review.** A second level Grievance review is available to Insureds dissatisfied with the first level Grievance review decision. The Insured has the right to appear in person at a Second Level Review and present his or her case to the review panel. The Insured may submit supporting material both before and at the review meeting; ask questions of any representative of the Company; and be assisted or represented by a person of his or her choice. The Insured will be notified by the Company 15 days prior to the date of the Grievance review meeting. The Company shall not unreasonably deny a request by the Insured for postponement of the review.

The Company will convene a second-level Grievance review panel for each request. The panel shall be comprised of health care professionals who are clinical peers and who were not previously involved in any matter giving rise to the second-level Grievance, are not employees of the Company, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level Grievance involving an Adverse Determination shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if the Company used a clinical peer on an appeal on a first-level Grievance review panel then the Company may use one of its employees on the second-level Grievance review panel in the same matter if the second-level Grievance review panel comprises three or more persons.

When the Insured requests to appear before the Company's Second Level panel review, the Company shall

1. Within 45 days of receipt of the second level review request, hold the second level Grievance review meeting during regular business hours at a location reasonably accessible to the Insured. When a face-to-face meeting is not practical for geographic reasons, the Company shall offer the Insured the opportunity to communicate with the review panel, at the Company's expense, by conference call, video conferencing, other appropriate technology.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

2. Upon request by the Insured, the Company shall provide the Insured with all relevant, nonconfidential or privileged information.
3. If the Company will have an attorney present to argue its case against the Insured, the Company shall so notify the Insured at least 15 working days in advance of the second level Grievance review meeting date and shall advise the Insured of their right to obtain legal representation.
4. The Insured will have the right to full review without condition of his/her attendance at the meeting.
5. A written statement of the second level Grievance review panel's decision shall be issued to the Insured within 5 working days after the review meeting. The decision shall include:
 - i. the names, titles and qualifying credentials of the person or persons evaluating the appeal;
 - ii. a statement of the reviewers' understanding of the reason for the Insured's request for an appeal
 - iii. the reviewers' decision in clear terms and the basis of the decision in sufficient detail for the Insured to respond further to the Company's position;
 - iv. a reference to the evidence or documentation used as the basis for the decision;
 - v. notice of the availability of the Superintendent's office for assistance, including the telephone number and address of the Bureau of Insurance;
 - vi. notice advising of any subsequent appeal rights, and the procedure and time limitation for exercising those rights including the notice of external review rights.

EXTERNAL REVIEW PROCEDURES

An Insured may request an independent external review of the Company's Adverse Health Care Treatment decision. An Insured's failure to obtain authorization prior to receiving an otherwise Covered Medical Expense does not prevent the Insured from requesting an external review. An Insured will be notified of their right to an External Review on the written notice of an Adverse Health Care Treatment Decision. The Maine Bureau of Insurance administers this service.

1. Request for external review.

- a. An Insured or the Insured's authorized representative must make a written request for external review of an Adverse Health Care Treatment Decision to the Maine Bureau of Insurance. Except as provided for an Expedited Request for External Review, an Insured may not make a request for external review until the Insured has exhausted all levels of the Company's internal grievance procedure. A request for external review must be made within 12 months of the date an Insured has received a final Adverse Health Care Treatment Decision under the Company's internal grievance procedure. An Insured may not be required to pay any filing fee as a condition of processing a request for external review.

2. Expedited request for external review.

- a. An Insured or an Insured's authorized representative is not required to exhaust all levels of the Company's internal grievance procedure before filing a request for external review if:
 - b. The Company has failed to make a decision on an internal Grievance within the time period required;
 - c. The Company and the Insured mutually agree to bypass the internal grievance procedure;
 - d. The life or health of the Insured is in serious jeopardy; or
 - e. The Insured has died.

3. External Review Decisions

An external review decision must be made in accordance with the following requirements.

- a. The independent review organization (IRO) must give consideration to the appropriateness of the requested covered service based on the following:
 - i. All relevant clinical information relating to the Insured's physical and mental condition, including any competing clinical information;
 - ii. Any concerns expressed by the Insured concerning the Insured's health status; and
 - iii. All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the Company.

UTILIZATION REVIEW, GRIEVANCE AND EXTERNAL REVIEW PROCEDURES *(continued)*

- b. An external review decision must be issued in writing and must be based on the evidence presented by the Company and the Insured or the Insured's authorized representative. An Insured may submit and obtain evidence relating to the Adverse Health Care Treatment decision under review, attend the external review, ask questions of any representative of the Company present at the external review and use outside assistance during the review process at the Insured's own expense.
- c. Except for Expedited External review, the external review decision must be made by the IRO within 30 days of receipt of a completed request for external review from the bureau.
- d. Expedited External review decisions must be made as expeditiously as an Insured's medical condition requires but in no event more than 72 hours after receipt of a completed request.
- e. The Company shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an Insured who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an Insured who is visually impaired.
- f. An external review decision is binding on the Company. An Insured or the Insured's authorized representative may not file a request for a subsequent external review involving the same Adverse Health Care Treatment decision for which the Insured has already received an external review decision. However, an external review decision made under this provision is not considered final agency action.
- g. The Company shall pay the cost of the independent external review to the bureau.

Insured Persons, his/her designated representative, or a provider may contact the Company at 2301 West Plano Parkway, Suite 300, Plano, Texas 75075 or at 1-800-767-0700.

Insured Persons, his/her designated representative, may also contact the State of Maine Bureau of Insurance for assistance at any time at 1-800-300-5000 or write to State of Maine, Bureau of Insurance, 34 State House Station, Augusta, Maine 04333-0034.