

# 2006-2007

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

*Designed Especially For*

# International Community Service

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

International



Community Service

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

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

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

The Preferred Providers for this plan are **Beech Street, Inc.\***

*\*except specific state plans as listed below:*

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

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

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**PART I**  
**ELIGIBILITY AND TERMINATION PROVISIONS**

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

## 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.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025, or to any authorized agent of the Company, 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 180 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:** All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, 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.

## 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.

### PART III DEFINITIONS

**COINSURANCE** means the percentage of Covered Medical Expenses that the Company pays.

**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.

**COPAYMENT** means a fixed dollar amount that an Insured must pay each time Covered Medical Expenses are provided.

**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.

**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).

## **DEFINITIONS (Continued)**

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

**HOSPITAL** means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder. Hospital includes a duly licensed state tax-supported institution as defined in Statute 58-251.6 of the North Carolina Insurance Code.

**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.

**IN-NETWORK COVERED MEDICAL EXPENSES** means Covered Medical Expenses that are received under the terms of the policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

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

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

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

## **DEFINITIONS (Continued)**

**MEDICAL EMERGENCY** means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- 1) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- 2) Serious impairment of bodily functions;
- 3) Serious dysfunction of any body organ or part.

Medical Emergency services include health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

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

**MEDICAL NECESSITY** means those services or supplies that are:

- 1) Provided for the diagnosis, treatment, cure, or relief of a health condition, Sickness or Injury and, not for experimental, investigational, or cosmetic purposes;
- 2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, Sickness or Injury, or its symptoms;
- 3) Within generally accepted standards of medical care in the community;
- 4) Not solely for the convenience of the Insured, the Insured's family, or the Physician.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity.

**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, ADOPTED OR FOSTER CHILD** means any child born of an Insured or placed with an Insured while that person is insured under this policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects or birth abnormalities including treatment of cleft lip and cleft palate, prematurity and nursery care. The Pre-existing Conditions limitation will not apply to a Newborn Infant, Adopted or Foster Child.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. If additional premium is required to continue the coverage, the Insured must, within the 31 days after the child's birth or placement: 1) apply to us; and 2) pay the required additional premium 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 or placement.

If family coverage is in force and no additional premium is required, enrollment/notification of the new Dependent within the specified period of time will not be required nor penalties applied for failure to do so.

**OUT-OF-NETWORK COVERED MEDICAL EXPENSES** means non-emergency Covered Medical Expenses that are not received according to the terms of the policy including services from affiliated providers that are received without the approval of the Company.

**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.

**DEFINITIONS** *(Continued)*

**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 those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a sixth-month period immediately preceding 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.

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

## **PART IV**

### **EXTENSION OF BENEFITS AFTER TERMINATION**

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

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

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

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

**PART IV  
SCHEDULE OF BENEFITS  
MEDICAL EXPENSE BENEFITS  
INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN  
2006-201594-92  
INJURY AND SICKNESS BENEFITS**

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

The Preferred Provider for this plan is Medcost in North Carolina and Beech Street when outside of North Carolina.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

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

| <b>Inpatient</b>   | <b>Preferred Provider</b>  | <b>Out-of-Network</b>  |
|--|--|--|
| <b>Room &amp; Board / Hospital Misc.:</b>  | Preferred Allowance/\$100 co-pay per day for 1 <sup>st</sup> 3 days              | Usual & Customary Charges/\$100 Deductible per day for 1 <sup>st</sup> 3 days          |
| <b>Intensive Care:</b>   | Paid under Room & Board/Hospital Misc.   | Paid under Room & Board/Hospital Misc.   |
| <b>Routine Newborn Care:</b>   | Paid as any other Sickness/4 days Hospital Confinement expense maximum           | Paid as any other Sickness/4 days Hospital Confinement expense maximum                 |
| <b>Physiotherapy:</b> ( <i>\$2,500 maximum total for Inpatient and Outpatient combined.</i> )  | Preferred Allowance/\$2,500 maximum  | Usual & Customary Charges/\$2,500 maximum  |
| <b>Surgery:</b> ( <i>Specified surgery based on data provided by Ingenix.</i> )  | Preferred Allowance  | Usual & Customary Charges  |
| <b>Assistant Surgeon:</b>  | Paid under Surgery   | Paid under Surgery   |
| <b>Anesthetist:</b>  | Paid under Surgery   | Paid under Surgery   |
| <b>Registered Nurse's Services:</b>  | Preferred Allowance  | Usual & Customary Charges  |
| <b>Physician's Visits:</b>   | Preferred Allowance  | Usual & Customary Charges  |
| <b>Pre-admission Testing:</b>  | Paid under Room & Board/Hospital Misc.   | Paid under Room & Board/Hospital Misc.   |
| <b>Psychotherapy:</b>  | Paid as any other Sickness/Preferred Allowance/30 days maximum (Per Policy Year) | Paid as any other Sickness/Usual & Customary charges/30 days maximum (Per Policy Year) |
| <b>Outpatient</b>  | <b>Preferred Provider</b>  | <b>Out-of-Network</b>  |
| <b>Surgery:</b> ( <i>Specified surgery based on data provided by Ingenix.</i> )  | Preferred Allowance  | Usual & Customary Charges  |
| <b>Day Surgery Miscellaneous:</b> ( <i>Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.</i> ) | Preferred Allowance/\$150 co-pay   | Usual & Customary Charges/\$150 Deductible   |
| <b>Assistant Surgeon:</b>  | Paid under Surgery   | Paid under Surgery   |
| <b>Anesthetist:</b>  | Paid under Surgery   | Paid under Surgery   |
| <b>Physician's Visits:</b>   | Preferred Allowance/\$20 co-pay per visit  | Usual & Customary Charges/\$20 Deductible per visit                                    |

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2006-201594-92**  
**INJURY AND SICKNESS BENEFITS**

| <b>Outpatient (Continued)</b>  | <b>Preferred Provider</b>  | <b>Out-of-Network</b>  |
|--|--|--|
| <b>Physiotherapy:</b>  | Preferred Allowance/\$2,500 maximum  | Usual & Customary Charges/\$2,500 maximum  |
| <i>(\$2,500 maximum total for Inpatient and Outpatient combined). (Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)</i>   |  |  |
| <b>Outpatient Misc. Benefits:</b>  | No Benefits  | No Benefits  |
| <b>Medical Emergency:</b>  | Preferred Allowance/\$150 co-pay per visit   | 80% of Usual & Customary Charges/\$150 Deductible per visit  |
| <b>X-rays &amp; Laboratory:</b>  | Preferred Allowance/\$20 co-pay per test   | Usual & Customary Charges/\$20 Deductible per test   |
| <b>Radiation Therapy/Chemotherapy:</b>   | Preferred Allowance/\$1,000 maximum  | Usual & Customary Charges/\$1,000 maximum  |
| <b>Tests &amp; Procedures:</b>   | Preferred Allowance/\$20 co-pay test   | Usual & Customary Charges/\$20 Deductible per test   |
| <b>Psychotherapy:</b>  | Paid as any other Sickness/Preferred Allowance/30 visits maximum (Per Policy Year)/\$20 co-pay per visit | Paid as any other Sickness/Usual & Customary charges/30 visits maximum (Per Policy Year)/\$20 Deductible per visit |
| <b>Prescription Drugs:</b>   | 80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)                                       | 80% of Usual & Customary Charges/\$2,000 maximum (Per Policy Year)   |
| <b>Other</b>   |  |  |
| <b>Ambulance:</b> <i>(includes ground and air transportation.)</i>   | 80% of Usual & Customary Charges/\$200 maximum   | 80% of Usual & Customary Charges/\$200 maximum   |
| <b>Durable Medical Equipment:</b>  | 80% of Usual & Customary Charges   | 80% of Usual & Customary Charges   |
| <b>Consultant:</b>   | Preferred Allowance  | Usual & Customary Charges  |
| <b>Dental:</b><br><i>(Injury to Sound, Natural Teeth only.)</i>  | 80% of Usual & Customary Charges/\$100 maximum per tooth/\$500 maximum (Per Policy Year)                 | 80% of Usual & Customary Charges/\$100 maximum per tooth/\$500 maximum (Per Policy Year)                           |
| <b>Alcoholism/Drug Abuse:</b>  | Paid under Psychotherapy   | Paid under Psychotherapy   |
| <b>Maternity:</b><br><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   |
| <b>Elective Abortion:</b>  | Paid as any other Sickness/\$500 maximum (Per Policy Year)   | Paid as any other Sickness/\$500 maximum (Per Policy Year)   |
| <b>Complications of Pregnancy:</b>   | Paid as any other Sickness   | Paid as any other Sickness   |
| <b>Repatriation:</b>   | Benefits provided by Assist America, Inc.  | Benefits provided by Assist America, Inc.  |
| <b>Medical Evacuation:</b>   | Benefits provided by Assist America, Inc.  | Benefits provided by Assist America, Inc.  |
| <b>*AD&amp;D:</b>  | See Endorsement  | See Endorsement  |
| <b>Intercollegiate Sports:</b>   | No Benefits  | No Benefits  |
| <b>MRI/Cat Scan:</b>   | Preferred Allowance/\$1,200 maximum (Per Policy Year)/\$100 co-pay per test                              | Usual & Customary Charges/\$1,200 maximum (Per Policy Year)/\$100 Deductible per test                              |
| <b>Child Health Assurance:</b><br><i>(The benefits shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age. "Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Minimum Benefits are limited to one visit payable to one provider for all services provided at each visit. Benefits shall not be subject to the Deductible, but are subject to all copayment, coinsurance, limitations, or any other provisions of the policy.)</i> | Preferred Allowance  | Usual & Customary Charges  |
| <b>Cervical Cytology Screening:</b>  | See Benefits for Cervical Cancer Screening   | See Benefits for Cervical Cancer Screening   |

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2006-201594-92**  
**INJURY AND SICKNESS BENEFITS**

**MAJOR MEDICAL**

**Maximum Benefit** **No Benefits**

**CATASTROPHIC MEDICAL**

**Maximum Benefit** **No Benefits**

**Conversion Permitted:** Yes  No

**\*Pre-Admission Notification:** Yes  No

**52 week Benefit Period** or  **Extension of Benefits**

**Other Insurance:**  **Excess Insurance**

**Primary Insurance**

\*If benefit is designated, see endorsement attached.

**SCHEDULE OF BENEFITS (Continued)**  
**MEDICAL EXPENSE BENEFITS**  
**INTERNATIONAL COMMUNITY SERVICE – VANTAGE PLAN**  
**2006-201594-92**  
**INJURY AND SICKNESS BENEFITS**

**PREFERRED PROVIDER INFORMATION**

“**Preferred Providers**” are the Physicians, Hospitals and other health care providers of Medcost in North Carolina and Beech Street when outside of North Carolina who have contracted to provide specific medical care at negotiated prices.

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.

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

“**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%, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

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

**Outpatient Hospital Expenses**

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

**Professional & Other Expenses**

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

**NOTICE**

The Insured’s actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine plan and Insured payment obligations.

**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.
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 Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.

## 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 Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits. Benefits are limited to one visit per day.
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 and Drug Abuse:** 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.
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 EMERGENCY SERVICES**

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access prehospital emergency services when appropriate for treatment of a Medical Emergency.

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

**BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER**

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder ("TMJ"). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatment of TMJ is subject to a lifetime maximum benefit of \$3,500. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

**BENEFITS FOR CERVICAL CANCER SCREENING**

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Examinations and laboratory tests" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

**BENEFITS FOR MAMMOGRAPHY**

Benefits will be paid the same as any other Sickness for Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
  - a. The woman has a personal history of breast cancer;
  - b. The woman has a personal history of biopsy-proven benign breast disease;
  - c. The woman's mother, sister, or daughter has or has had breast cancer; or
  - d. The woman has not given birth prior to the age of 30.
2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.
3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.
4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

## **BENEFITS FOR SURVEILLANCE TESTS FOR WOMEN AT RISK FOR OVARIAN CANCER**

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

“At risk for ovarian cancer” means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

“Surveillance tests” mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

## **BENEFITS FOR COLORECTAL CANCER SCREENING**

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, medically necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

## **BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS**

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

## **BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY**

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphademas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

“Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

“Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. “Reconstructive breast surgery” also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

## **BENEFITS FOR MATERNITY TESTING**

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. Certain maternity tests are not covered under the policy based on this exclusion. The most common maternity procedures not covered or limited are as follows: Serum and Amniotic Alpha-fetoprotein (AFP), Amniocentesis and Chromosome studies are not covered at all. Lab tests for Glucose, HIV, Chlamydia and Toxoplasmosis are covered only if actual symptoms exist to cause the test to be diagnostic. One ultrasound is allowed regardless of diagnosis. For multiple ultrasounds, Medical Necessity must be established with medical records. Payable prenatal labs include ABO, Rh, CBC, Syphilis screen, Rubella screen and Hepatitis B surface antigen. One initial urinalysis and pap smear is also allowed. Fetal Stress/Non-Stress tests are payable only for a diagnosis which adversely effects the health of the mother. Pre-natal vitamins are not covered.

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

## **BENEFITS FOR DIABETES**

Benefits will be paid the same as any other Sickness for medically necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician.

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

## **BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES**

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

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

## **BENEFITS FOR BONE MASS MEASUREMENT**

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when medically necessary. Conditions that may be considered medically necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:

- a. an individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- b. an individual with radiographic osteopenia anywhere in the skeleton;
- c. an individual who is receiving long-term glucocorticoid (steroid) therapy;
- d. an individual who primary hyperparathyroidism;
- e. an individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- f. an individual who has a history of low-trauma fractures; or
- g. an individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

## **BENEFITS FOR PRESCRIPTION CONTRACEPTIVES**

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

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

## **BENEFITS FOR NEWBORN HEARING SCREENING**

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

**PART VII  
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 a Newborn Infant or Adopted or Foster Child;
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for a Newborn Infant or Adopted or Foster Child; 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 or as specifically provided in the policy;
13. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
14. Injury sustained while (a) participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
15. Organ transplants, including organ donation;
16. 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;

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

17. Voluntary participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
18. Pre-existing Conditions except for individuals who have been continuously insured under the ICS's student insurance policy for at least 6 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
19. Prescription Drugs, services or supplies as follows:
  - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
  - b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
  - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI);
  - 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;
20. 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;
21. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
22. 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;
23. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
24. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
25. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
26. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
27. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

**EXCLUSIONS AND LIMITATIONS (Continued)**

28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
30. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
31. Weight management, weight reduction, nutrition programs, treatment for obesity, (except surgery for morbid obesity), surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

# 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:

## GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES GRIEVANCE PROCEDURES

The following levels of review are available to Insured Persons or providers who have a complaint or a Grievance.

**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 a Noncertification as defined.

**Noncertification** means a determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service is therefore denied, reduced or terminated. A noncertification is not a decision rendered solely on the basis that the policy does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A noncertification includes any situation in which the Company or its designated agent makes a decision about an Insured's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the policy is affected by that decision.

The levels of review include an Informal Review and Formal Review.

### INFORMAL REVIEW

An Insured Person may submit a written complaint to the Company for informal review after an event that causes a dispute.

- 1) If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured, the Company shall treat the request as a first-level Grievance review, except that on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner, the Company will provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.
- 2) If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company shall issue a written decision that includes the availability of the Commissioner's office for assistance, including the telephone number and address of the office.
- 3) If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company shall treat the request as a first-level Grievance review, except that on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.

### FORMAL REVIEW

The Formal Review process includes a First Level, Second Level and Expedited Review Process.

#### FIRST LEVEL GRIEVANCE REVIEW

- 1) An Insured or an Insured's provider acting on the Insured's behalf may submit a Grievance.
- 2) The first level Grievance material must be submitted in writing by the Insured or his/her provider for consideration by the first level reviewer.

## **GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES (Continued)**

- 3) With the exception of Grievances concerning the quality of care received, within 3 business days after the Company receives the request for a first-level Grievance review, the Company must provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.
- 4) The Insured may or may not attend this review but is not required to do so.
- 5) The Company will issue a written decision, in clear terms, to the Insured and, if applicable, the Insured's provider, within 30 days of the receipt of the Grievance. The person or persons reviewing the Grievance shall not be the same person or persons who initially handled the matter that is the subject of the Grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level Grievance review shall contain:
  - a. The professional qualifications and licensure of the person or persons reviewing the Grievance.
  - b. A statement of the reviewer's understanding of the Grievance.
  - c. The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position.
  - d. A reference to the evidence or documentation used as the basis for the decision.
  - e. A statement advising the Insured of his or her right to request a second-level Grievance review and a description of the procedure for submitting a second-level Grievance.
- 6) For Grievances concerning the quality of clinical care delivered by the Insured's provider, the Company shall acknowledge the Grievance within 10 business days. The acknowledgement shall advise the Insured that:
  - a. The Company will refer the Grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and
  - b. State law does not allow for a second-level Grievance review for Grievances concerning quality of care.

### **SECOND LEVEL GRIEVANCE REVIEW**

- 1) A second level Grievance review is available to Insureds dissatisfied with the first level Grievance review decision. An Insured or an Insured's provider acting on the Insured's behalf may submit a second level Grievance.
- 2) Within 10 days of the receipt of the request for the second level review, the Company will provide the following information to the Insured:
  - a. The name, address and telephone number of the Grievance review coordinator.
  - b. A statement of the Insured's rights, including the right to:
    - i. Request and receive from the Company all information relevant to the case;
    - ii. Present his/her case to the review panel;
    - iii. Submit supporting material prior to and at the review meeting;
    - iv. Ask questions of any member of the panel;
    - v. Be assisted or represented by a person of the Insured's choosing, including a family member, employer representative or attorney.
- 3) The Company will convene a second-level Grievance review panel for each request. The panel shall be comprised of persons 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 a Noncertification or clinical issue 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.
- 4) The second level Grievance review meeting will be held within 45 days of receipt of the second level review request.
- 5) The Insured will receive at least 15 days notice of the second level Grievance review meeting date.

## **GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES *(Continued)***

- 6) The Insured will have the right to full review without condition of his/her attendance at the meeting.
- 7) A written statement of the second level Grievance review panel's decision shall be issued to the Insured within 7 business days after the review meeting. The decision shall include:
  - a. The professional qualifications and licensure of the members of the review panel.
  - b. A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts.
  - c. The review panel's recommendation to the Company and the rationale behind that recommendation.
  - d. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
  - e. In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
  - f. The rationale for the Company's decision if it differs from the review panel's recommendation.
  - g. A statement that the decision is the Company's final determination in the matter.
  - h. Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

### ***EXPEDITED SECOND-LEVEL GRIEVANCE REVIEW PROCEDURES***

- 1) An expedited second level review is available whether or not the initial review was expedited. The Company may require documentation of medical justification in accordance with 58-50-61(1).
- 2) An expedited second level review will meet the requirements for a non-expedited second level review with the following differences:
  - a. The review proceeding must take place and the decision communicated to the Insured within 4 business days of receiving all necessary information.
  - b. The review meeting must take place via conference call or the exchange of written information.

Insured Persons, his/her designated representative, or a provider may contact Student Insurance at 4001 McEwen, Suite 300, Dallas, TX 75244 or at 1800-767-0700.

The Grievance Procedures describe above are voluntary. The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. The Insured may inquire in writing to the Department at P O Box 26387, Raleigh, NC 27611 or by telephone at 1-800-546-5664.

### **EXTERNAL REVIEW**

North Carolina law provides for review of Noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to the Insured, arranging for an IRO to review the Insured's case once the NCDOI establishes that the Insured's request is complete and eligible for review. The Insured or the Insured's authorized representative may request an external review. The Company will notify the Insured in writing of his/her right to request an external review each time the Insured:

1. receives a Noncertification decision, or
2. receives an appeal decision upholding a Noncertification decision, or
3. receives a second-level grievance review decision upholding the original Noncertification.

In order for the Insured's request to be eligible for external review, the NCDOI must determine the following:

1. that the request is about a Medical Necessity determination that resulted in a Noncertification decision;
2. that the Insured had coverage with the Company in effect when the Noncertification decision was issued;

## **GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES (Continued)**

3. that the service for which the Noncertification was issued appears to be a covered service under the policy; and
4. that the Insured has exhausted the Company's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, the Insured will be considered to have exhausted the internal review process if he/she has:

1. completed the Company's appeal and second level grievance review and received a written second level determination from the Company, or
2. filed a second level grievance and except to the extent that the Insured has requested or agreed to a delay, has not received the Company's written decision within 60 days of the date the Insured submitted the request, or
3. received notification that the Company has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

If the Insured's request for a standard external review is related to a retrospective Noncertification (a Noncertification which occurs after the Insured has received the services in question), the Insured will not be eligible to request a standard review until he/she has completed the Company's internal review process and received a written final determination from the Company.

If the Insured wishes to request a standard external review, he/she (or his/her representative) must make this request to NCDOI within 60 days of receiving the Company's written notice of final determination that the services in question are not approved. When processing the request for external review, the NCDOI will require the Insured to provide the NCDOI with a written, signed authorization for the release of any of their medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of the Insured's request for a standard external review, the NCDOI will notify the Insured and his/her provider of whether the request is complete and whether it is accepted. If the NCDOI notifies the Insured that his/her request is incomplete, the Insured must provide all requested additional information to the NCDOI within 90 days of the date of the Company's written notice of final determination. If the NCDOI accepts the Insured's request, the acceptance notice will include

1. the name and contact information for the Independent Review Organization (IRO) assigned to the case;
2. a copy of the information about the Insured's case that the Company has provided to the NCDOI; and
3. notification that the Insured may submit additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If the Insured chooses to provide any additional information to the IRO, the Insured must also provide that same information to the Company at the same time using the same means of communication (e.g., the Insured must fax the information to the Company if it was faxed to the IRO). When faxing information to the Company, send it to 1-xxx-xxx-xxxx. If mailing the information, send it to:

**The Company**  
**P. O. Box 809025**  
**Dallas, Texas 75380-9025**

Please note that this additional information may also be sent to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and the Company. The NCDOI will forward this information to the IRO and the Company within two business days of receiving the additional information.

## **GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES (Continued)**

The IRO will send the Insured written notice of its determination within 45 days of the date the NCDOI received the standard external review request. If the IRO's decision is to reverse the Noncertification, the Company will, reverse the Noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the Noncertification decision. If the Insured is no longer covered by the policy at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a Noncertification decision may be available if the Insured has a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function. If the Insured meets this requirement, the Insured may make a written or verbal request to the NCDOI for an expedited review after the Insured:

1. receives a Noncertification decision from the Company and files a request with the Company for an expedited appeal, or
2. receives an appeal decision upholding a Noncertification decision and files a request with the Company for an expedited second level grievance review, or
3. receives a second-level grievance review decision upholding the original Noncertification.

The Insured may also make a request for an expedited external review if the Insured receives an adverse second-level grievance review decision concerning a Noncertification of an admission, availability of care, continued stay or emergency care, but has not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review the Insured's request and determine whether it qualifies for expedited review. The Insured and the Insured's provider will be notified within 3 days if the request is accepted for expedited external review. If the request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if the Company's internal review process was already completed, or (2) require the completion of the Company's internal review process before the Insured may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective Noncertifications.

The IRO will communicate its decision to the Insured within 4 days of the date the NCDOI received the request for an expedited external review. If the IRO's decision is to reverse the Noncertification, the Company will, within one day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply that is the subject of the noncertification decision. If the Insured is no longer covered by the policy at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

For further information about External Review or to request an external review, contact the NCDOI at:

**By Mail:**

NC Department of Insurance; Healthcare External Review Program; P.O. Box 26387; Raleigh, NC 27611-6387  
(fax)919-715-1175

**In Person:**

Dobbs Building; 430 N. Salisbury St.; 4th Floor, Suite 4105; Raleigh, NC  
(Toll-free in NC) 1-877-885-0231  
(Out of NC) 1-919-715-1163

The IRO's external review decision is binding on the Company and the Insured, except to the extent the Insured may have other remedies available under applicable federal or state law. The Insured may not file a subsequent request for an external review involving the same Noncertification decision for which the Insured has already received an external review decision.

**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:

|                     | <b>STUDENT</b> | <b>SPOUSE</b> | <b>CHILD</b> |
|---------------------|----------------|---------------|--------------|
| 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.

The Accidental Death benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

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.**

