

Medical Pamphlet
AFS Intercultural Programs
May 2010

Including information on the Participant Medical Plan and the
Additional Benefits Program provided to all AFS participants.

AFS MEDICAL PAMPHLET HIGHLIGHTS Persons covered	Participants on AFS Exchange Programs
Territory	Worldwide, except in the participant's home country.
Period of Coverage	Coverage starts when participant arrives at international departure site and lasts until the date of departure from the AFS program or upon the return to the home country, whichever comes first.
Medical Coverage	Medical Expenses per covered loss: up to \$1,000,000 Evacuation and Repatriation Expenses: up to \$300,000 Accidental Death Benefit: \$ 10,000
Deductibles and Co-Payments	None
Major Exclusions (See pages XX for detailed list)	<ul style="list-style-type: none"> • Routine vision care (eye exams, glasses, contact lenses), except that due to accidents • Dental care, except that due to accidents. (See section on Supplemental Insurance for additional dental care benefit.) • General physical exams • Sports physical exams, vaccinations, immunizations • Any pre-existing condition; that is, one for which treatment has been sought or provided in the eighteen month period prior to the participant's arrival at the international departure site.
Filing Medical Claims:	<p>In USA: GMMI 7901 S.W. 36th Street Davie FL 33328 e-mail: Customerservice@gmmusa.com Phone: 1-800-633-1860</p> <p>Outside USA: Aon Consulting AFS Claims Team Ronald Enderman Admiraliteitskade 62 Postbus 1005, 3000 BA Rotterdam The Netherlands (31) 10-448-8238 afs@aon.nl</p>
Medical Emergency Numbers: (Refer to medical ID cards for details)	Travel Guard : In the USA: (1) ; 866-272-6233 Outside USA: (1) 713-267-3338 (call collect)

<u>TABLE OF CONTENTS</u>	<u>PAGES</u>
I. Introduction	4
II. What is secondary insurance?	4
III. Definitions	4-6
Medical Expenses Paid under the Plan	
Eligible participants	
Covered losses	
Maximum limits paid	
Deductibles and co-payments	
Territory of coverage	
When coverage begins and ends	
IV. Medical Expenses	6
V. Medical ID Cards	7
VI. Medical Assistance Service	7
VII. Medical Evacuation, including air ambulance	8
VIII. Repatriation Expenses	8
IX. Exclusions to the Plan	9-10
Routine vision and dental expenses	
Routine physical exams, inoculations or preventative care	
Pre-Existing conditions	
Full exclusions list	
X. Filing Medical Claims	11-12
For expenses incurred in the US	
For expenses incurred in countries other than the US	
In the event of a car accident	13
Additional Benefits Insurance Coverage Summary	14-22
Accidental Death & Dismemberment	15
Emergency Dental	15
Reunion Benefits	16
Trip Interruption Benefits	16
“Tail” Medical Insurance	17
Permanent Disability	18
Bereavement and Trauma Counseling	19
General Exclusions to all Additional Benefits	19
Claims Submission for Additional Benefits	22

Medical Expenses for Participants on AFS Programs

I. Introduction

AFS provides the Participant Medical Plan, an extensive secondary medical insurance, because health care costs and insurance vary so widely from country to country. The purpose of the plan is to make sure that prompt, suitable medical treatment is given to an AFS participant anywhere in the world, whenever needed. If a participant gets unexpectedly hurt or ill while on an AFS program, AFS seeks to ensure that his or her covered participant medical expenses will be paid.

The Participant Medical Plan is discussed in the Participation Agreement, which families sign as part of the student admissions process. The purpose of this pamphlet is to describe the medical expenses which are covered by the terms of the Participation Agreement as well as to describe those expenses that are not covered.

The Participant Medical Plan covers direct medical expenses. The insurance company is the Insurance Company of the State of Pennsylvania (ICSP). ICSP is one of the companies of Chartis Inc.

AFS also provides additional travel insurance benefits in addition to the medical benefits in the Participant Medical Plan. These are called “Additional Benefits” and further assist participants who have been affected by illness or injury. Additional Benefits are described in the back of this pamphlet.

II. What is Secondary Insurance?

The concept of “primary” and “secondary” insurance is well established in the health insurance industry. The AFS Participant Medical Plan acts as a form of secondary coverage—it is ultimately responsible for medical expenses only if the expenses are not payable through a primary policy first, such as a national health plan or private insurance held by the natural family.

The process of “recovering expenses” helps AFS to control the cost of its medical plan. Whenever possible, AFS will seek to have any available primary insurance reimburse AFS for incurred medical claims. When no primary insurance exists the Participant Medical Plan acts as primary source of payment for medical expense. This makes it possible for the Participant Medical Plan to continue to pay for the expenses in the many cases in which participant primary insurance is not available, is not sufficient, or does not address the entire medical problem.

III. Definitions

What is Covered under the Plan

When we refer to the term “**coverage**” we mean the agreement made to pay for these kinds of expenses for eligible participants:

Medical Expenses
Medical Evacuation, including air ambulance
Repatriation Expenses

Each of these types of coverage is explained in a section in this pamphlet.

An **eligible participant** is an approved participant of AFS Intercultural Programs.

A “**covered loss**” is an accident or illness that is not excluded by the Participant Medical Plan. While the Participant Medical Plan pays for a broad array of losses it does not cover every kind of loss. There is a list of exclusions, or medical expenses that are not covered, in Section X, pages 7-9.

AFS also provides “Additional Benefits” to participants. This package of benefits also responds to covered accidents or illness, but covers more than the basic medical expenses addressed by the Medical Plan:

- Accidental Death and Dismemberment
- Dental benefit for the alleviation of pain
- Reunion benefit
- Trip Interruption benefit
- Permanent Total Disability benefit
- “Tail Medical” benefit,
- Bereavement and trauma counseling benefit

The terms and conditions for these benefits are different than coverage under the Participant Medical Plan, so the Additional Benefits are described separately in the last section of this pamphlet.

Limit of Coverage for an Accident or Illness

As described in the Participation Agreement, the Participant Medical Plan provides coverage to participants of up to USD \$1,000,000 per covered loss while they are on an AFS program. This is the maximum amount available to cover the **cost** of medical expenses.

AFS does not provide coverage beyond USD \$1,000,000 for any single covered loss for medical expenses. However, medical evacuation and repatriation losses are covered up to an additional \$300,000

If a participant were to suffer more than one accident or illness, a new coverage limit would apply to each loss.

Deductibles and Co-payments

Participants are not asked to pay any deductibles or co-payments under this program.

Territory of Coverage

The Participant Medical Plan operates worldwide.

It does not respond to losses incurred in the home country of the participant. This does not apply when part of the participant’s AFS program, such as orientation, takes place in the home country.

When Coverage Begins and Ends

Coverage begins as soon as the participant reaches the international departure site for embarking on the AFS program, such as an airport or a pre-departure orientation. As long as a participant continues to participate in the AFS program, he or she is eligible for coverage under the participant medical plan.

Participation in the AFS program means carrying out the normal activities required of an AFS participant. Participants are required to attend school or participate in their community service project or other structured activities listed in the program description on a full-time basis. Other required activities include, but are not limited to, active participation in the life of the host family, attendance at AFS local and regional events, and engagement in typical extra-curricular and social activities. The final determination on whether the participant is able to remain on the program rests with AFS.

Coverage ends on the date of departure from the AFS Program or upon the return to the home country, whichever comes first.

Once the participant has left the AFS program or returned home, the Participant Medical plan ends and his or her medical expenses become the responsibility of the natural family, even if the accident, injury or illness causing them happened during the program.

For this reason natural families should make sure before the departure on an AFS program that other insurance or medical care is available in the home country should their child return requiring medical assistance. It may not be possible to obtain coverage once the participant is already sick or injured since it could be classified as a pre-existing condition. *For this reason, AFS strongly advises that natural families maintain insurance for their child while he or she is on an AFS program.*

The Additional Benefits program offers a benefit called “Tail Medical” that can help to address limited expenses arising from accidents or endemic disease that occurred on the AFS program but continue to produce medical expenses after the participant has returned home. See the last section of this pamphlet for an explanation of this benefit

IV. Medical Expense Coverage

Medical Expense refers to expenses incurred for appropriate medical care by an eligible participant while they are on an AFS program. The Participant Medical Plan pays only for the medical expenses of covered losses, which are accidents or illnesses not excluded by the Plan.

Covered medical expenses under the Participant Medical Plan are:

1. Charges made by a hospital for room and board, floor nursing and other services, including charges for professional services, except personal services of a non-medical nature, provided, however, that expenses do not exceed the hospital’s average charge for semi-private room and board accommodation;
2. Charges made for diagnosis, treatment and surgery by a physician;
3. Charges made for the cost and administration of anesthetics;
4. Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood transfusions, iron lungs, and medical treatment;

5. Charges for physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist;
6. Hotel room charge, when the AFS participant, otherwise necessarily confined in a hospital, shall be under the care of a duly qualified physician in a hotel room owing to unavailability of a hospital room by reason of capacity or distance or to any other circumstances beyond control of insured;
7. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a physician or surgeon.

The Additional Benefits program offers specific benefits that can apply as well to cases of assault or to coma arising from injury. There is also a benefit that can be used for counseling about trauma that results from a covered accident. See the section on Additional Benefits in the back of this pamphlet.

Refer to the Exclusions section X of this pamphlet for a listing of expenses which are not covered under the Participant Medical Plan.

It is the responsibility of the natural family to provide for the coverage of those medical expenses of the participant which are excluded under the Participant Medical Plan. If AFS pays for these expenses upfront in order to assist the participant at the time of illness or injury, natural parents will be required to reimburse the Participant Medical Plan.

V. Medical Identification Cards

AFS provides participants with a medical ID card which they can use to certify that they have medical expense coverage. Each card lists the 24-hour telephone number which a doctor or hospital can call to confirm coverage for an eligible participant when the national hosting office is closed or when a true medical emergency exists.

VI. Medical Assistance Service

In order to fulfill its responsibilities to participants, AFS works with Travel Guard, which provides medical assistance to travelers. Travel Guard helps AFS to *obtain* or *qualify* medical care around the world and also to arrange for medical evacuation, when needed.

Obtaining medical care means finding personnel and facilities which are appropriate for managing a participant's medical condition while they are in their host country. It also means getting medical evaluations, or providing participants with medicine while they are on the AFS program.

Qualifying medical care means determining that the facility in the host country where a participant may already be hospitalized is appropriate for their care. It can also mean getting a second opinion from a local doctor or from a doctor employed by the assistance network.

Travel Guard has a medical team on staff on a 24-hour basis. They complement the existing network of AFS Partners and volunteers around the world when there is a medical problem. Medical assistance allows AFS International as well as the AFS hosting Partner and sending Partner to confer with medical

specialists in the time of an emergency. They can also jointly get assessments on the case and keep in touch on its developments.

In the event that a participant is hospitalized for more than 24 hours, the Additional Benefits program provides a Reunion Benefit that can permit a family member to travel to the participant. See the description of this benefit in the last section of this pamphlet.

Should another kind of medical care or facility be recommended for the participant, the assistance network will arrange their transfer within the host country, or to a facility in the participant's home country.

VII. Medical Evacuation

Medical Evacuation refers to the expenses of transporting a seriously ill participant and sometimes a chaperone required by medical order. It usually results in a return to the participant's home country. This means the end of the participant's AFS program stay and the termination of medical coverage once the participant has been taken to their home or the required medical facility.

Sometimes a participant may need to be transported to another location in the host country to receive suitable medical care while they continue on the AFS program. The Participant Medical Plan will pay for medical costs occurring after this evacuation only if the participant can stay actively involved in AFS program activities.

In very unusual cases, doctors may suggest transfer to a medical care facility that is neither in the home country nor in the host country. AFS defines this to be a termination of the participant's program stay. In this case, the Participant Medical Plan will cover the cost of the medical evacuation but medical coverage will terminate after the participant's arrival at the medical facility and medical expenses will revert to the natural parents.

The Additional Benefits program offers a Trip Interruption benefit that can be useful when the ill or injured participant has already been medically evacuated to a medical facility and needs to continue home from that place. See more about the Trip Interruption benefit in Additional Benefits section in the back of this pamphlet.

The Participant Medical Plan will arrange and cover the expenses of a medical evacuation when a doctor gives written orders that a participant requires one. These arrangements must be made through Travel Guard. They can range from an early return on a commercial airliner to a specially equipped jet with medical facilities and personnel. Medical evacuation does not cover the cost of travel for any other persons or for any other reasons.

If a participant needs to travel back home because of the medical condition of a family member, a separate benefit will provide coverage for these expenses. This benefit is the Trip Interruption Benefit in the Additional Benefits program and is described in the back of this pamphlet.

VIII. Repatriation Expenses

Please note that **Repatriation Expense** does not refer to medical evacuation or any regular travel expenses. It refers to the special travel arrangements that must be made when someone covered by the

Plan has died. In that event, AFS will make all necessary arrangements with Travel Guard. The Participant Medical Plan pays for repatriation expenses when they arise from a covered loss.

IX. Exclusions to the Participant Medical Plan

Not every medical expense is the responsibility of the Participant Medical Plan. Some kinds of expenses, such as those that participants can **expect, elect, or control** are not intended to be covered by the Plan.

Other types of excluded expenses are those not considered **medically necessary**. The Participant Medical Plan is designed only to cover the expenses of the unexpected medical services and items which a doctor says are needed to restore a participant's health.

Finally, some types of expenses can't be covered because they can't be adequately evaluated, like the risk of **war in the home country of the participant, or in the US**.

Routine Vision and Dental Expenses

As described in the Participation Agreement, the Participant Medical Plan does not pay for certain types of medical expenses which are expected as part of daily life. These include **routine vision care**, such as routine eye exams, glasses or contact lenses. Dental coverage under the Participant Medical Plan is limited to dental treatment needed as a result of an accident, as recommended by a doctor.

The Additional Benefits program offers a limited Dental Benefit intended for the alleviation of pain. See the description in the back of this pamphlet.

Expenses for Routine Physical Exams or Preventative Care

The Participant Medical Plan does not pay for **routine physicals, inoculations, vaccinations, or examinations**, even if required by schools. As an example, schools often require sports physical examination prior to allowing participants to engage in school sports. Participants and/or natural parents are expected to pay for these expenses directly. If the host family or AFS should pay for these expenses, the claims administrator will seek reimbursement from the natural family.

What is a Pre-Existing Condition?

In addition, as noted in the Participation Agreement, the Participant Medical Plan does not pay for medical expenses that come from pre-existing conditions. A **pre-existing condition** is one for which treatment has been sought or provided in the eighteen-month period prior to the participant's arrival at the international departure site.

When the Participant Medical Plan pays for medical expenses which are determined to have been a result of a pre-existing condition, the administrator will require reimbursement by the natural family. If a participant has a condition which qualifies as pre-existing, the natural family should make arrangements to pay for the expenses relating to this condition should they arise during the course of the AFS program. If there is an insurance policy in effect which covers the condition, the natural family should keep the coverage in force during the course of the AFS program.

Summary of expenses excluded because they are to be expected or are elective

- Routine vision care
- Routine dental care
- Routine physical exams
- School physical exams
- Inoculations
- Vaccinations
- Pre-existing conditions
- Birth control treatment

Listing of Exclusions to the Participant Medical Plan

- Services, supplies or treatment not certified as necessary and reasonable by a physician
- Medical expenses incurred in the home country of the participant or of participants who have left the program for any reason.
- Dental care, except as the result of injury to sound natural teeth caused by an accident. Jaw augmentation or reduction surgery is also excluded.
- Routine vision care, including eyeglasses, eye refraction, and contact lenses.
- General physical examinations, including sports physicals, where there are no objective indications of impairment of normal health.
- Inoculations or immunizations.
- Pre-existing conditions which were diagnosed or treated within eighteen months prior to the participant's arrival at the international departure site.
- Cosmetic surgery except as the result of an accident.
- Newborn or child care
- Suicide or attempted suicide while sane or self-destruction or attempt while insane.
- Intentionally self-inflicted injury
- Service in the military.
- Expenses which are payable by any other insurance or governmental health program
- Expenses that are non-medical in nature
- Expenses arising from war that occurs in the United States, Iran, Iraq, Afghanistan or the home country of the participant.
- Skydiving, professional and amateur racing, and piloting an aircraft
- For injury sustained while participating in professional athletics

X. Filing Medical Claims for Medical Plan Expenses

Medical Expense claims are processed in two ways, according to the location in which they are produced. They should be filed within one year of first incurring the medical expense.

Claims incurred in the US

When a participant incurs a medical expense in the US, please ask the doctor or hospital to send the original bill with their claim form directly to the Third Party Administrator for ICSP claims in the US.

That is:

GMMI (Global Medical Management Inc.)
7901 S.W. 36th Street
Davie, FL 33328

e-mail: customerservice@gmmusa.com

If the medical expense is paid by the participant or the host family, they can claim reimbursement from ICSP by submitting the bill to GMMI. In this case, it is important that they use the claim form provided by AFS. Care should be taken to fill out the entire AFS claim form detailing the nature of the treatment required.

Balance Billing

The claims administrator, GMMI, negotiates with medical providers to reduce their costs even after they have provided the medical service. Medical providers often agree to forgo part of their fee, but sometimes they may still send the part of the bill that was not paid to the natural family. This practice is called “balance billing”. If you receive a bill for all or part of a medical expense that you thought was covered under the Participant Medical Plan, let GMMI know. Send them an email (customerservice@gmmusa.com) with the details of the claim and describe the bill you received.

GMMI makes it possible for AFS families to view the medical bills that GMMI has received. You can also see the bills that have been processed for payment to the medical providers.

Should you receive a “balance bill” or a statement by mail, you can log on to their web site at: www.gmmusa.com. Press the “Insured Patients” button located in the upper right hand corner of the screen. Follow the directions by entering the Policy ID, First Name, Last Name and Date of Birth before pressing “View Patient Info”. *(The Policy ID number is found on both ID Cards provided to the participant by AFS USA and begins with the 3 letter country code of the participant’s home country: e.g. CRC for Costa Rica, GER for German, ITA for Italy, JPN for Japan, THA for Thailand, etc.)*

On the next page you will be able to view a listing of all the bills that have been received by GMMI. The first column lists the Internal Tracking Number at GMMI for a specific bill. The second column lists the medical provider’s name. The third column lists the treatment date. The fourth column lists the total charges billed. The fifth column lists the payment date (which is printed in green if it has been already paid or printed in red if payment is pending or has been denied), and the last column lists the date the bill was processed

If the statement you have received is listed online with GMMI for the same amount you do not have to do anything further.

If the statement you have received is not listed online with GMMI, please first contact the provider and inform them of the insurance information and GMMI's billing address so that they can send the proper claim form to GMMI for handling. Then please e-mail or fax a copy of the statement to GMMI at: customerservice@gmmusa.com or via fax number 954 370 8130.

If you have any questions or are not able to access your information online, please call GMMI at 954 370 6468 or 888 444 7773

Calling for information about medical expenses in the US

Doctors, host families or participants can talk to GMMI about claims or coverage by calling 1-888-444-7773. Their office hours are 9 a.m. to 4:30 p.m. Monday through Friday.

Questions that arise about medical emergencies in the US after office hours should be directed to AFS at (212) 299-9000.

Claims incurred in countries other than the US

The national office of the hosting partner determines how claims will be handled in that country. Participants and host families should contact the national office for information on how to file medical claims.

ICSP uses a Third Party Claims Administrator in Europe, who is the Aon Consulting, Admiraliteitskade 62, Rotterdam, Netherlands. They are also available during normal working hours to answer questions on coverage by calling (31) (10) 448-8238. E-mail: afs@aon.nl

In addition, Aon Consulting helps to coordinate medical insurance available to European Union participants who are traveling in countries with EC insurance arrangements. Please contact Aon as soon as medical care is required for these participants so that they can arrange for the claim to be properly paid through EU channels. Often these arrangements must be made before medical care is sought in order to be properly covered.

AON is the administrator for any death or dismemberment claims occurring anywhere in the world, and also for the Additional Benefits program, which is described in the back of this pamphlet.

Calls about claims or coverage after hours may be directed to Travel Guard at the telephone numbers indicated on the Highlights page of this pamphlet.

In the event of a car accident

If a participant has been injured in a car accident, it is important that an **accident report** accompany the claim information. This report is usually obtained from the police.

The accident report should show the names, addresses and relevant insurance information of all drivers involved in the accident.

Please note that when medical expenses are incurred by participants as the result of an automobile accident, responsibility for the expenses is often governed by local law.

In many countries, automobile insurance is mandatory, and the Participant Medical Plan will look to that coverage first for the payment of claims. This means that the person(s) who owns the car(s) involved in the accident will be asked by the claims administrator for their insurance information.

In the US, expenses are the responsibility of:

- the owner of the vehicle in which the participant was a passenger, if the accident happened in a state with no-fault laws
- the auto insurance of the driver at fault, if the accident happened in a state without no-fault laws.

1. Additional Benefits Coverage Summary

AFS provides a package of additional travel-related benefits for AFS participants. This insurance is provided by the Insurance Company of the State of Pennsylvania, also known as Chartis, and is in effect for all participants on AFS programs.

This program offers seven kinds of benefits that can be helpful with illness or injury that happens during travel, but that are not covered under the Participant Medical Plan.

1. AD & D	\$10,000	Benefit paid in event of death. Lesser benefits paid for other kinds of losses, such as loss of limb or faculties. Coma and paralysis benefit also provided.
2. Emergency Dental	Up to \$500	For dental treatment for the alleviation of pain
3. Emergency Reunion	Up to \$5,000	Airfare and/or lodging for immediate family member to visit participant hospitalized for 24 hours or more.
4. Trip Interruption Benefit	Up to \$5,000	Airfare for participant to return home due to life-threatening illness, injury, or death of immediate family member
5. “Tail” Medical	Up to \$100,000	Covers medical expenses incurred up to one year after return to home country as a result of an accident (but not illness, other than endemic disease) incurred while on the AFS program.
6. Permanent Disability	Up to \$100,000	Benefit for permanent and total disability arising from an accident (not illness, other than endemic disease) incurred while on an AFS program.
7. Bereavement and Trauma Counseling	Up to 10 sessions at maximum of \$100 per session	Available to participant and/or family members, as a result of a covered accident or endemic disease suffered by participant.

Additional Benefits are provided in addition to coverage provided under the Participant Medical Plan. The terms and conditions of coverage for these benefits are different from the terms and condition of the coverage for The Medical Plan, which covers medical expenses, medical evacuation and repatriation. No deductibles or co-pays are payable by the participant.

Additional Benefits provide “secondary” coverage and are not payable if there is primary insurance available either through private or national health insurance.

All seven Additional Benefits are subject to the exclusions listed at the end of this pamphlet. Some exclusions apply specifically to certain benefits.

A more detailed description of the seven benefits is explained below:

1. Accidental Death and Dismemberment

In the event of a participant's death, the Participant Medical Plan will provide a benefit of \$10,000 in addition to the limit provided for covered medical expenses. Note that Accidental Death coverage is payable only as a result of a loss occurring within 365 days of a covered accident. No benefit is payable from losses caused by illness, with the exception of endemic disease. An endemic disease is one belonging exclusively or confined to a particular place or people living in the locale that the participant was visiting, such as malaria.

In the event of a loss of limbs, eyes, hearing or speech, or a combination of these losses, the Participant Medical Plan will provide a benefit of up to \$10,000, depending on the exact nature of the loss and based on the schedule of payments as stipulated in the insurance policy. Please contact the National AFS Office for specific details on payments for these losses, as well as information on coma, paralysis, and home/vehicle adaptation benefits.

Paralysis: The AD & D benefit will pay 100% of the AD & D benefit in the event of complete and irreversible quadriplegia resulting from a covered loss, including injury or endemic disease. It will pay 75% of the benefit in the event of paraplegia (complete and irreversible paralysis of lower limbs) or hemiplegia (complete and irreversible paralysis of one side). If a disability benefit is also payable arising from the same accident, the paralysis benefit will not apply.

Felonious Assault: There is a benefit payable of \$5,000 for a loss that occurs during a violent crime or felonious assault. There must be a police report filed that shows an intentional assault. The crime must be classified as a felony in the location where the assault occurred, such as an actual or attempted robbery or holdup. Coverage does not extend to assault committed by the participant, a family member, or member of the same household.

Home Alteration and Vehicle Modification: There is a benefit payable of \$5,000 when the insured suffers a covered loss, other than loss of life, that results directly from a covered accident and requires adaptive devices or adaptations to residence or vehicle in order to maintain an independent lifestyle. This requirement must occur within one year of the date of the covered accident, and the insured must not have needed these adaptations before. Expenses must be directly attributable to alterations that are strictly necessary.

Note that the AD & D benefit does not cover any loss resulting from sickness or disease, other than endemic disease. This includes bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except for bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.

2. Emergency Dental:

This provides coverage up to \$500 for the immediate alleviation of pain. Coverage applies for 30 days after the covered sickness or accident occurs. Expenses can be paid for up to 26 weeks from the date of the sickness or accident.

Alleviation of pain and infection to teeth and alleviation of pain and infection to gums is covered. This includes treatment of abscesses and impacted wisdom teeth.

Most dental restoration service, such as the fixing of fillings, crowns, or bridges is not covered, unless the procedure must be done for the direct alleviation of pain. Routine restorations and amalgams are not covered.

Services, supplies, or treatment, including any period of hospital confinement that are not recommended, approved, and certified as medically necessary are not covered. Treatment by a family member is not covered, nor expenses which would not be payable in the absence of this insurance.

Routine dental care and treatment is not covered. Damage to or loss of orthodontic devices is not covered. TMJ, or temporo-mandibular joint disorder or related conditions are not covered.

Accidental injury to sound, natural teeth is covered under the Participant Medical Plan to policy limits, as long as the expenses arise as a direct result of a covered injury.

See the full listing of exclusions that apply to this benefit in the back of this pamphlet.

3. **Reunion Benefit**

This provides coverage up to \$5,000 for economy travel and/or lodging for an immediate family member to visit a participant who has been hospitalized for more than 24 consecutive hours due to a covered injury or sickness, and where the attending doctor believes it would be beneficial to have the family member at the participant's side.

In the case of grave injury or sickness, where the participant's life is in danger, the benefit can be extended to accommodate two family members. This is subject to the approval of the administrator and is subject to the benefit maximum of \$5,000.

“Immediate Family Member” means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild), grandchild and grandparent.

All travel arrangements must be made through the AFS Partner and approved by the administrator, AON, in order to be covered.

4. **Trip Interruption Benefit**

This provides coverage for airfare up to \$5,000 for an economy air and/or ground transportation ticket. This applies if the participant must travel home because an immediate family member has died or is experiencing a life-threatening illness or injury, as determined by a doctor. The illness or injury must be so disabling as to reasonably cause the trip to be interrupted.

The benefit also provides for economy transportation to return the participant to the AFS program as determined by AFS. Both the travel home and the return cannot exceed the limit of \$5,000.

“Immediate Family Member” means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild), grandchild and grandparent.

This benefit may also be used when the participant is ill or injured, has been medically evacuated to a medical facility, and needs to continue the journey home from that place.

All travel arrangements must be made through the AFS Partner and approved by the administrator, AON, in order to be covered. Any existing tickets must be used first.

5. **“Tail” Medical Insurance:**

This provides coverage for eligible medical expenses up to \$100,000. It applies to expenses incurred up to one year after a participant returns to the home country as a result of injuries sustained in a covered accident or an endemic disease contracted while on an AFS program.

Treatment must be for the recurrence or continuation of treatment for an injury or endemic illness that originated on the AFS program. For example, if a participant broke an arm while on an AFS program and obtains surgery or treatment recommended by a doctor upon return home, these expenses could be covered under this benefit.

Expenses arising as a result of illness while on an AFS program are not covered, unless caused by endemic disease. An endemic disease is one belonging exclusively or confined to a particular place or people living in the locale that the participant was visiting, such as malaria. The first incurred expenses must happen within 90 days of the date of the covered sickness. All related conditions and recurrent symptoms of the same or similar condition will be considered one covered sickness.

Expenses covered under the Tail Medical benefit are:

- Charges made by a hospital for room and board, floor nursing and other services, including charges for professional services, except personal services of a non-medical nature, provided, however, that expenses do not exceed the hospital’s average charge for semi-private room and board accommodation;
- Charges made for diagnosis, treatment and surgery by a physician;
- Charges made for the cost and administration of anesthetics;
- Charges for medication, x-ray services, laboratory tests and services, the use of radium and radio-active isotopes, oxygen, blood transfusions, iron lungs, and medical treatment;
- Charges for physiotherapy, if recommended by a physician for the treatment of a specific disablement and administered by a licensed physiotherapist;
- Hotel room charge, when the AFS participant, otherwise necessarily confined in a hospital, shall be under the care of a duly qualified physician in a hotel room owing to unavailability of a hospital room by reason of capacity or distance or to any other circumstances beyond control of insured;
- Dressings, drugs, and medicines that can only be obtained upon a written prescription of a physician or surgeon.

In some cases the coverage offered under Additional Benefits is not as broad as that provided under the Participant Medical Plan. For example, expenses from an injury that was caused by intoxication by alcohol would be covered under the Participant Medical Plan. These expenses would not be covered under the Tail Medical Benefit.

Coverage applies to losses arising from “activities while participating in an AFS sponsored program”. The coverage excludes claims that are not considered to be directly related to AFS activities (for example, business ventures not related to an AFS program or host family activity).

The Tail Medical benefit responds only to sickness that arises from endemic illness. It does not respond to other disease or infection other than bacterial infection arising from a cut or a wound, or accidental ingestion of contaminated food.

The following conditions are excluded from coverage: treatment of hernia, Osgood-Schlatter’s Disease (which causes bone pain in adolescents), osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an injury, or mental or nervous treatment, whether or not caused by a covered accident. Expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain are not covered.

Expenses arising from pregnancy, childbirth, miscarriage or abortion are not covered, and neither is cosmetic surgery except for reconstructive surgery needed as a result of an injury. Suicide or any attempted suicide is not covered.

Tail medical coverage does not respond to injuries that are incurred while the participant is legally intoxicated, or under the influence of any drug except under the advice and consent of a doctor.

See the back of this pamphlet for more exclusions that apply to the Tail Medical benefit.

6. **Permanent Disability Insurance:**

This provides a benefit of up to \$100,000 as a result of permanent and total disability due to an accident that occurs while on the AFS program. No benefits for disability due to an illness are payable, unless the illness occurs as a result of endemic disease. An endemic disease is one belonging exclusively or confined to, a particular place or people living in the locale that the participant was visiting. An example is malaria.

Permanent total disability means that, because of an injury from a covered accident that happens on, or an endemic disease contracted on the AFS program, the participant cannot perform the normal and customary activities of a person of like age and gender, and is expected to remain so disabled, as certified by a doctor, for the rest of their life. There is no coverage for disability that is permanent but not total, or for disability that is total but not permanent.

Losses attributable to mental or nervous conditions are not covered. The disability benefit is payable one year from the date of the accident or endemic disease that caused the loss.

Coma. There is a benefit payable of \$10,000 if the insured becomes comatose within 31 days of a covered accident and remains in a coma for 31 days. Coma arising from illness other than endemic

disease is not covered. 1% of the benefit is payable monthly for 11 months and then as a lump sum after 12 months

See the back of this pamphlet for more exclusions that apply to the Disability benefit.

7. Bereavement and Trauma Counseling Benefit

This benefit covers a maximum of ten sessions at a maximum of \$100 per session. The sessions may be for the participant and/or one or more of his or more immediate family members, as a result of a covered accident to the participant that caused the loss. Illness, with the exception of endemic disease, is not a covered cause of loss. The counseling must be provided under the care, supervision or order of a doctor, and is covered only if there would have been a charge for the service had this benefit not existed.

The expenses must be incurred within one year from the date of the covered accident or endemic disease causing the loss. This benefit can be used in conjunction with the Tail Medical benefit.

“Immediate Family Member” means a person who is related to the Participant in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild), grandchild and grandparent.

GENERAL EXCLUSIONS TO ALL “ADDITIONAL BENEFITS”; AD&D, Dental, Reunion, Trip Interruption, Tail Medical, Permanent Total Disability, and Bereavement and Trauma Counseling.

These exclusions apply in addition to those stipulated in the descriptions of the seven Additional Benefits.

Note that these exclusions are separate and distinct from those that apply to the Medical Plan. Those are described in a separate section in this pamphlet.

This insurance does not cover any event which either in origin or extent, directly or indirectly, proximately or remotely is to be attributed to or is a consequence of:

Suicide, or attempted suicide while sane or attempted self-destruction while insane

Intentionally self-inflicted injury (this exclusion does not apply to the AD&D benefits)

Expenses paid by any automobile insurance policy without regard to fault (this exclusion does not apply to the AD& D benefits)

Injury that occurs while the covered person is legally intoxicated or under the influence of any drug unless administered under the advice and consent of a doctor (this exclusion does not apply to the AD & D benefits)

Commission of, or attempt to commit, a felony

Piloting or serving as a crewmember in any aircraft

Flying in any aircraft being used for stunt or acrobatic flying, stunt racing, endurance testing, with rocket propulsion, crop dusting, banner towing, inspection, herding, aerial photography or requiring any special permit

Military service

Sickness or disease other than endemic disease, except for bacterial infection arising from external cut or wound or accidental ingestion of contaminated food (this exclusion does not apply to the tail medical benefit)

Treatment provided by a person employed or retained by AFS or by an immediate family or household member

Expenses covered under Workers' Compensation laws

Expenses arising from engaging in activity for monetary gain that are unrelated to the AFS program. Elective or experimental surgery, examination, health treatment or supplies not recognized and generally practiced under established medical standards in the country in which the treatment is occurring. Pregnancy, childbirth, miscarriage, abortions or any complications of these

Mental or nervous illness

Cosmetic surgery except for reconstructive surgery required as a result of an accident

Eyeglasses, contact lenses, hearing aids, wheelchair, braces, appliances, examinations or prescriptions for them or repair or replacement of orthotic devices

Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an Injury, or mental disorder or psychological or psychiatric care of treatment (except as provided for in the Policy), whether or not caused by a covered accident.

Temporomandibular or craniomandibular joint dysfunction and associated myofascial pain

Damage to existing orthodontic equipment, or damage to or loss of bridges or dentures

Conditions that are not caused by a covered accident or endemic disease

Procedures that are not considered to be medically necessary

Expenses that would not be payable in the absence of this policy

Treatment, service or supply not payable by the policy: War or any act of war, including terrorism, is covered except in the following countries: the United States, the Insured's Home Country, and the countries of Afghanistan, Iraq and Iran.

For a full description of the all terms and conditions governing these supplemental benefits, please refer to the Policy Wording for details. This is available from the local AFS national office.

Please note that this pamphlet is provided as a brief summary of coverage provided under the AFS Medical Plan and is not an insurance policy. If there is any discrepancy between the insurance policy and the pamphlet, the insurance policy will govern.

Claims Submission for the Additional Benefits program:

Claims should be submitted directly to Aon in the Netherlands. AON is the claims administrator for Chartis, the insurance company. Please note that expenses for the Additional Benefits program should not be sent to GMMI, as they are the claims administrators for the Medical Plan only, not for these benefits.

Original receipts and a description of the incident must accompany the claim. In some cases, a doctor's opinion or letter may be required to substantiate the claim or further treatment. Claims must be submitted to AON within 90 days after the date of the incident to:

Aon Consulting

AFS Claims Team

Ronald Enderman

Admiraliteitskade 62, Rotterdam
Postbus 1005, 3000 BA Rotterdam, **Netherlands**

email: **afs@aon.nl**
telephone: (31) 10 448 82 38
fax: (31) 10 448 87 24
AFS Website: **<http://www.aon.nl/AFS>**

Please note that claims submitted later than 90 days after the date of the occurrence may not be payable.

AFS Medical Pamphlet - Revised May 2010