BCS Insurance Company

Oakbrook Terrace, Illinois

MASTER POLICY
BLANKET HEALTH POLICY

This Master Policy (hereafter referred to as Master Policy or Policy) is issued to the Policyholder named in the Policy Schedule. It takes effect on the effective date shown in the Policy Schedule.

In return for the payment of premium, BCS Insurance Company ("the Company", "we", "us" or "our") will pay the benefits which this Master Policy provides for persons insured hereunder for certain losses, as specified in the DESCRIPTION OF BENEFITS, for loss due to Injury or Sickness that occurs while this Policy and the Covered Person's coverage are in force. The Master Policy is delivered in and is subject to the laws of the state in which it is issued.

We and the Policyholder have agreed to all of the terms of this Master Policy.

This is a legal contract between the Policyholder and Us.
READ THIS MASTER POLICY CAREFULLY.

Signed for the BCS Insurance Company.

SECRETARY

PRESIDENT

IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE PROVISION ENTITLED "WHEN COVERAGE ENDS" BEGINNING ON PAGE 8

EXCESS INSURANCE

Coverage under the Policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim then the amounts of benefits payable by such other medical insurance will become the deductible amount of the Policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

PLEASE NOTE – THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION

POLICY SCHEDULE

POLICYHOLDER:	Saint Augustine's College
POLICY NUMBER:	BSA-00118
POLICY EFFECTIVE DATE:	August 1, 2011
POLICY TERM:	The period beginning on the Policy Effective Date and ending at 12:01 A.M. on August 1, 2012.
PREMIUM DUE DATE:	As shown on the Premium Schedule.
ADMINISTRATOR:	Administrative Concepts, Inc.
RENEWABILITY:	Insurance may be renewed for any specified term by payment of the required premium for such term by the premium due date at the Company's premium rates in effect at the time of each such renewal and at benefit levels and provisions set forth by the Company.

TABLE OF CONTENTS

Amendatory Rider attached: 28.807(NC)(Rev. 04/04)

ELIGIBILITY

The Eligible Persons are:

Eligible Class	Description
Class 1	All International Students
Class 2	All Domestic Students
Class 3	(a) All Registered Students participating in intercollegiate athletics; and (b) all Intercollegiate Athletics Trainers, Managers, and Coaches.

Eligible Classes may be afforded the following Coverages;

On a mandatory basis:

Coverage/Benefit Description	Eligible Classes
24-Hour Accident and Sickness Coverage (Basic Medical Expense Benefit)	Classes 1 & 2
Intercollegiate Athletics-Only Coverage (Basic Medical Expense Benefit)	Class 3
Accidental Death, Dismemberment, and Loss of Sight Benefit	Classes 1, 2 & 3

On a voluntary basis:

24-Hour Accident and Sickness Coverage (Major Medical Expense Benefit)	Classes 1 & 2

PREMIUM SCHEDULE

Rate per Covered Person

Coverage Period	Mandatory
Annual (8/1/11 – 8/1/12)	$88
Fall Semester (8/1/11 – 2/12/12)	$44
Spring Semester (2/12/12 – 8/1/12)	$44
Summer Semester (6/1/12 – 8/1/12)	$26

	Voluntary Major Medical Expense Benefit
Annual (8/1/11 – 8/1/12)	$281
Semi-Annual (8/1/11 – 2/12/12; 2/12/12 – 8/1/12)	$141
Spring/Summer Semester (2/12/12 – 8/1/12)	$176

Premium Due Dates:
Annual, Initial Semi-annual, or Fall Semester: August 31, 2011
Second Semi-annual or Spring/Summer Semester: March 14, 2012
Summer Semester: July 1, 2012

SCHEDULE OF BENEFITS

BENEFITS
The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

The Pre-existing Condition Limitation (described on page 17) applies to all Covered Persons and Benefits.

I. Basic Medical Expense Benefit - Injury & Sickness

Benefits are payable on the following basis: Excess (See Excess Provision on page 9)

Applicable Coverage: Intercollegiate Athletics-Only Coverage

Maximum Benefit for All Covered Expenses per Injury: $90,000

Deductible Amount: $0

Coinsurance: 100%

Applicable Coverage: 24-Hour Accident and Sickness Coverage

Maximum Benefit for All Covered Expenses (per Injury or Sickness): $5,000

Deductible Amount:
- Per Injury - $50
- Per Sickness - $0

Coinsurance:
- Per Injury - 100%
- Per Sickness - 100% except as specified in the table below.

Maximum Amounts Payable for Specific Covered Expenses (per Injury or Sickness):

(Subject to Maximums for All Covered Expenses)
- Per Sickness: As specified in the table below.

Covered Expenses	Maximum Amount
Hospital Room & Board:	$500 per day
Hospital Miscellaneous, Inpatient:	$1,000
Surgery (Physicians' Fee):	$1,500
Assistant Surgeon:	25% of the Surgery Allowance
Anesthetist:	25% of the Surgery Allowance
Physician Visits	
Inpatient:	30 visits, $25 per visit
Outpatient:	$50
Outpatient Surgery Miscellaneous (Facility Fee):	$750
Outpatient Medical Emergency Room:	$150
Outpatient Diagnostic Xrays & Laboratory Procedures:	$100
Ambulance:	$250
Consultant Physician:	$75
Other Expenses; Mental Illness Treatment	
While hospital confined:	30 days to a maximum of $5,000
Outpatient treatment:	$50 per week to a maximum of $300

SCHEDULE OF BENEFITS (continued)

II. Major Medical Expense Benefit - Injury & Sickness

Benefits are payable on the following basis: Excess (See Excess Provision on page 11)

The voluntary Major Medical Expense Benefit is applicable to an individual Covered Person who has enrolled and paid the required premium.

Applicable Coverage: 24-Hour Accident and Sickness Coverage

Maximum Benefit for All Covered Expenses per Injury: $45,000

Deductible Amount: The Major Medical Deductible is considered to be met for an Injury or Sickness after the $5,000 Basic Medical Maximum becomes payable for that Injury or Sickness. Covered Expenses incurred thereafter are payable in accordance with the Major Medical Expense Benefit Description.

Coinsurance: 80%

Other Expenses (applies to Parts I and II).

The following expenses are considered Covered Expenses as described:

Colorectal Cancer Screening Benefit
Benefits are payable, subject to the same terms and conditions as a Sickness covered under the policy, for the Covered Expenses incurred by a Covered Person for colorectal cancer examinations and laboratory tests for cancer 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. Coverage under this benefit will apply to: (a) any non-symptomatic Covered Person age 50 or over; and (b) any non-symptomatic Covered Person under the age of 50 who is at a high risk for colorectal cancer according to the above guidelines.

III. Accidental Death or Dismemberment; Accidental Loss Of Sight Benefit

Applicable Coverages: Intercollegiate Athletics-Only Coverage, 24-Hour Accident and Sickness Coverage

Principal Sum: $2,000 (see Table of Benefits on page 13)

DEFINITIONS

Accident means a sudden, unexpected and unintended incident. "Covered Accident" means an Accident that results in Injury or loss covered by this Policy.

Covered Person means any Eligible Person who makes application for, or for whom application is made and who is approved to participate in the benefit plans issued under this Policy, provided the required premium for such Person's insurance is paid when due.

Hospital means a legally constituted institution having organized facilities for the care and Treatment of sick or injured persons on a registered Inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. Hospital shall also include duly licensed tax supported institutions which specialize in the treatment of one particular type of illness. Such facilities are not required to have an operating room and related equipment for the performance of surgery.

Injury means accidental bodily harm sustained by the Covered Person that resulted directly and independently of all other causes from an Accident and occurs while coverage under this Policy is in force.

Inpatient means confinement for which the Covered Person is charged at least one full day's room and board.

Intensive Care Unit means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and (1) is operated exclusively for the purpose of providing professional Treatment for critically ill patients; (2) has special supplies and equipment necessary for such Treatment which are available on a standby basis for immediate use; (3) provides room and board, and constant observation by registered graduate nurses or other specially trained Hospital personnel; and (4) is not maintained for the purpose of providing normal post-operative recovery Treatment or service.

Medically Necessary or Medical Necessity means the services or supplies that are (1) provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms; (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the Covered Person, the Covered Person′s family or the Physician or Hospital.

Nurse means a person who has been registered or licensed to practice by the State Board of Nurse Examiners or other state authority in the state where he works, and who is practicing within the scope and limitation of that license. The term Nurse will not include the Covered Person or his spouse, children, brothers, sisters, or parents, or any person residing in his household.

Outpatient Surgical Facility means a surgical or medical center, which has (1) permanent facilities for surgery; (2) organized medical staff of Physicians and registered graduate nurses; and (3) is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under that law.

Physician means a practitioner of the healing arts who is duly licensed in the state where he is practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person or his spouse, children, brothers, sisters, or parents, or any person residing in his household.

Pre-existing Conditions means a condition for which a Covered Person received medical treatment, care or advice within 6 months before being insured under this Policy.

School means the Policyholder.

Sickness means illness or disease contracted and causing loss as to the Covered Person whose Sickness is the basis of claim. Any complications or any condition arising out of a Sickness for which the Covered Person is being treated or has received Treatment will be considered as part of the original Sickness.

Treatment means a specific in-office or Hospital physical examination of, or care rendered to, the Covered Person.

Usual, Customary, and Reasonable Charges - "Usual" means those charges made by a provider for services and supplies rendered to all patients for the same or similar Injury or Sickness; "Customary" means those charges made by the majority of providers in the area for the same or similar services or supplies. "Reasonable" means those charges that do not exceed the majority of prevailing fees in the area for the same or similar services or supplies. Area means a county or larger geographically significant area as determined by the Company.

INDIVIDUAL INSURING PROVISIONS

Eligible Persons. The persons eligible for coverage are all persons denoted in the classifications described in the Eligibility Section.

Enrollment Period. Eligible Persons may enroll prior to departure to, or within 30 days of arrival in the country of assignment, or within 30 days of matriculation. Such participants are eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in the enrollment form.

When Coverage Begins. Any such Eligible Person will automatically become a Covered Person with respect to the coverage under this Policy at 12:01 A.M. on the latest of the following dates:

1. the effective date of this Policy; or
2. the date such Person comes within a classification of Eligible Persons, or
3. the date that a completed enrollment form (if any) and the required premium payment for such Person's coverage are received by the Company.

When Coverage Ends. Coverage with respect to any Covered Person will end at 12:01 A.M. on the earliest of the following dates:

1. the date this Policy is terminated; or
2. the premium due date, if the required premium is not paid within 31 days following such premium due date; or
3. the date such Covered Person ceases to come within any classification of Eligible Persons; or
4. the Coverage Expiration Date contained in the applicable COVERAGE DESCRIPTION.

In the event a Covered Person enters the armed forces, unearned premium will be returned, but the amount returned will only be for the number of full months of the unexpired term of coverage, less any administrative fees.

Coverage ending will not affect a claim for: (1) a covered accidental death or dismemberment loss due to an Accident that occurred while coverage was in effect as to the Covered Person; and (2) a Covered Expense due to an Injury or Sickness provided treatment is rendered within 52 weeks of the Injury or the onset of Sickness.

COVERAGE DESCRIPTIONS

Unless otherwise stated, we will pay benefits for a covered loss only once, even if coverage was provided under more than one Coverage Description.

A. INTERCOLLEGIATE ATHLETICS-ONLY COVERAGE

Effective Term: This coverage will be in effect with respect to a Covered Person from the effective date of the Policy and ending with the Coverage Expiration Date.

Coverage Expiration Date: The date described in the applicable provision titled When Coverage Ends in the section titled INDIVIDUAL INSURING PROVISIONS.

Description of Hazards: The hazards against which insurance is provided while this Policy and this Coverage are in force are such Injuries occurring to the Covered Person with regard to any intercollegiate athletic activity while participating in any of the following covered events:

1. practicing for or competing in such intercollegiate athletic activity; or
2. traveling for such intercollegiate athletic activity in a School-provided vehicle as a representative of the School and under the direct supervision of a full-time School employee; and
3. off-season training or conditioning programs.

Such athletic activity must be conducted under the regulations and jurisdiction of the applicable sports governing body.

B. 24-HOUR ACCIDENT AND SICKNESS COVERAGE

Effective Term: This coverage will be in effect with respect to a Covered Person from the effective date of the policy, or as described in the applicable provision titled When Coverage Begins (in the section titled INDIVIDUAL INSURING PROVISIONS), whichever is later, and ending with the Coverage Expiration Date.

Coverage Expiration Date: The date described in the applicable provision titled When Coverage Ends in the section titled INDIVIDUAL INSURING PROVISIONS.

Description of Hazards: All Covered Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one Injury or Sickness.

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE BENEFIT – INJURY AND SICKNESS

When Benefits are Payable: The Company will pay benefits for those Covered Expenses incurred by the Covered Person for Injury sustained or Sickness commencing while insured under this Policy and in accordance with the COVERAGE DESCRIPTION to which this benefit applies, provided the first such Covered Expense is incurred within 90 days after the date of the Accident or commencement of the Sickness.

Covered Expenses must be incurred within 52 weeks, or 104 weeks with respect to Intercollegiate Athletics-Only Coverage, after the date of the Accident or the date of the first Treatment for the Sickness. A Covered Expense will be deemed to have been incurred when the service or Treatment to which it relates is provided.

Amount of Benefits Payable: The amount of the benefit payable will be the eligible Covered Expenses incurred in excess of the Deductible Amount (if any) shown on the Schedule of Benefits, subject to:

1. any coinsurance amount applicable to such Covered Expense,
2. any maximum amount payable for a specific Covered Expense; and
3. any Maximum Benefit amount payable for all such Covered Expenses.

These amounts, if applicable, are as shown on the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of this Policy.

Excess Provision: The Company's liability for benefits due to Covered Expenses incurred for Treatments and services resulting from a covered Injury or Sickness will be limited in the manner shown on the Schedule of Benefits. When a Covered Expense is subject to this Excess Provision, the Company's liability is limited to that part of the Expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any other collectible policy or service contract, unless otherwise herein provided.

Covered Expenses: Covered Expenses will be limited to the Usual, Customary and Reasonable Charges incurred by the Covered Person for Medically Necessary care and Treatment. Covered Expenses include:

1. Room and Board Expense: (a) daily semi-private room rate when confined in a Hospital as an Inpatient; and (b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2. Hospital Miscellaneous Expenses: (a) while confined in a Hospital as an Inpatient; or (b) as a precondition for being confined in a Hospital as an Inpatient. Benefits will be paid for services and supplies such as: the cost of an operating room; laboratory tests; X-ray examinations (not treatment); anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
3. Inpatient Physiotherapy.
4. Inpatient Surgery: Physician's fees for Inpatient surgery. 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 the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both.
5. Inpatient Anesthetist Services: in connection with Inpatient surgery.
6. Inpatient Registered Nurse's Services: (a) private duty nursing care only; (b) while confined in a Hospital as an Inpatient; (c) ordered by a licensed Physician; and (d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
7. Inpatient Physician's Visits: when confined in a Hospital as an Inpatient, benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians' visits will be paid under this Inpatient Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.
8. Pre-admission Testing: limited to routine tests such as completed blood count; urinalysis; and chest X-rays. If otherwise payable under this Policy, major diagnostic procedures such as cat-scans and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. Pre-admission testing must occur within 3 working days prior to Hospital admission for this benefit to be payable.
9. Inpatient Psychotherapy: as noted on the Schedule of Benefits.
10. Outpatient Surgery: Physician's fees for outpatient surgery. 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 the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this outpatient surgery benefit or under the Inpatient surgery benefit, but not both.
11. Scheduled Outpatient Surgery Miscellaneous: in connection with outpatient surgery that is scheduled prior to its being performed. Benefits will be paid for services and supplies such as: the cost of the operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a Hospital, an Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.
12. Outpatient Anesthetist Services: in connection with scheduled outpatient surgery.
13. Outpatient Physician's Visits: benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.
14. Outpatient Physiotherapy: benefits are limited as shown on the Schedule of Benefits. Service must be prescribed by a licensed physician, and such prescription is for a stated number of visits.
15. Outpatient Medical Emergency Expenses: benefits will be paid for the use of the emergency room and supplies.
16. Outpatient Diagnostic X-ray Services: 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.
17. Outpatient Laboratory Procedures: laboratory procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
18. Outpatient Tests and Procedures: diagnostic services and medical procedures when performed by a Physician (excluding Physician's visits; physiotherapy; X-rays; and laboratory procedures).
19. Outpatient Injections: when (a) administered in a Physician's office; and (b) charged on the Physician's statement.
20. Outpatient Prescription Drugs (for Injury Only).
21. Outpatient Psychotherapy: as noted in the Schedule of Benefits. Benefits are limited to one visit per day.

22. Ambulance Services.
23. Outpatient Braces and Appliances: when (a) prescribed by a Physician; and (b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment, which is equipment, that: (a) is primarily and customarily used to serve a medical purpose; (b) can withstand repeated use; and (c) generally is not useful to the person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
24. Inpatient and outpatient Consultant Physician Fees: when requested and approved by the attending Physician.
25. Dental Treatment: when (a) performed by a Physician and (b) made necessary by Injury to sound, natural teeth. Routine dental care and treatment to the gums are not covered.
26. Other Expense: if applicable and as noted on the Schedule of Benefits.

MAJOR MEDICAL EXPENSE BENEFIT - INJURY AND SICKNESS

When Benefits are Payable: After the Maximum Benefit under the MEDICAL EXPENSE BENEFIT has been paid to the Covered Person, the Company will pay benefits for those Covered Expenses incurred by such Covered Person in accordance with the COVERAGE DESCRIPTION to which this benefit applies.

Covered Expenses must be incurred within 52 weeks after the date of the Accident or the date of the first Treatment for the Sickness. A Covered Expense will be deemed to have been incurred when the service or Treatment to which it relates is provided.

Amount of Benefits Payable: The amount of the benefit payable will be the eligible Covered Expenses incurred, subject to:

1. any coinsurance amount applicable to such Covered Expense,
2. any maximum amount payable for a specific Covered Expense; and
3. any Maximum Benefit amount payable for all such Covered Expenses.

These amounts, if applicable, are as shown on the Schedule of Benefits.

Payment of this benefit is subject to all other terms and conditions of this Policy.

Excess Provision: The Company's liability for benefits due to Covered Expenses incurred for Treatments and services resulting from a covered Injury or Sickness will be limited in the manner shown on the Schedule of Benefits. When a Covered Expense is subject to this Excess Provision, the Company's liability is limited to that part of the Expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any other collectible policy or service contract, unless otherwise herein provided.

Covered Expenses: Covered Expenses will be limited to the Usual, Customary and Reasonable Charges incurred by the Covered Person for Medically Necessary care and Treatment. Covered Expenses include:

1. Room and Board Expense: (a) daily semi-private room rate when confined in a Hospital as an Inpatient; and (b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2. Hospital Miscellaneous Expenses: (a) while confined in a Hospital as an Inpatient; or (b) as a precondition for being confined in a Hospital as an Inpatient. Benefits will be paid for services and supplies such as: the cost of an operating room; laboratory tests; X-ray examinations (not treatment); anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies.
3. Inpatient Physiotherapy.
4. Inpatient Surgery: Physician's fees for Inpatient surgery. Payment for surgery 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 the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both.
5. Inpatient Anesthetist Services: in connection with Inpatient surgery.
6. Inpatient Registered Nurse's Services: (a) private duty nursing care only; (b) while confined in a Hospital as an Inpatient; (c) ordered by a licensed Physician; and (d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

7. Inpatient Physician's Visits: when confined in a Hospital as an Inpatient, benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians' visits will be paid under this Inpatient Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.
8. Pre-admission Testing: limited to routine tests such as completed blood count; urinalysis; and chest X-rays. If otherwise payable under this Policy, major diagnostic procedures such as cat-scans and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. Pre-admission testing must occur within 3 working days prior to Hospital admission for this benefit to be payable.
9. Inpatient Psychotherapy: as noted on the Schedule of Benefits.
10. Outpatient Surgery: 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 the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this outpatient surgery benefit or under the Inpatient surgery benefit, but not both.
11. Scheduled Outpatient Surgery Miscellaneous: in connection with outpatient surgery that is scheduled prior to its being performed. Benefits will be paid for services and supplies such as: the cost of the operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a Hospital, an Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.
12. Outpatient Anesthetist Services: in connection with scheduled outpatient surgery.
13. Outpatient Physician's Visits: benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.
14. Outpatient Physiotherapy: benefits are limited as shown on the Schedule of Benefits. Service must be prescribed by a licensed physician, and such prescription is for a stated number of visits.
15. Outpatient Medical Emergency Expenses: benefits will be paid for the use of the emergency room and supplies.
16. Outpatient Diagnostic X-ray Services: 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.
17. Outpatient Laboratory Procedures: laboratory procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
18. Outpatient Tests and Procedures: diagnostic services and medical procedures when performed by a Physician (excluding Physician's visits; physiotherapy; X-rays; and laboratory procedures).
19. Outpatient Injections: when (a) administered in a Physician's office; and (b) charged on the Physician's statement.
20. Outpatient Prescription Drugs (for Injury Only).
21. Outpatient Psychotherapy: as noted in the Schedule of Benefits. Benefits are limited to one visit per day.
22. Ambulance Services.
23. Outpatient Braces and Appliances: when (a) prescribed by a Physician; and (b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment, which is equipment, that: (a) is primarily and customarily used to serve a medical purpose; (b) can withstand repeated use; and c) generally is not useful to the person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
24. Inpatient and outpatient Consultant Physician Fees: when requested and approved by the attending Physician.
25. Other Expense: if applicable and as noted on the Schedule of Benefits.

ACCIDENTAL DEATH, DISMEMBERMENT AND ACCIDENTAL LOSS OF SIGHT BENEFIT

When Benefits Are Payable: If, within 365 days of an Accident covered under this Policy in accordance with the COVERAGE DESCRIPTION to which this benefit applies, bodily Injury results in any of the following losses, the Company will pay the benefit amount shown opposite such loss in the Table of Benefits. If the Covered Person sustains more than one such loss as the result of any one Accident, the Company will pay only the one largest amount to which the Covered Person is entitled.

Table of Benefits

Covered Loss	**Benefit Amount**
Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and Entire Sight of One Eye	The Principal Sum
Loss of One Foot and Entire Sight of One Eye	The Principal Sum
Loss of One Hand	One-Half The Principal Sum
Loss of One Foot	One-Half The Principal Sum
Loss of Entire Sight of One Eye	One-Half The Principal Sum

Loss of hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of Entire Sight means the total, permanent loss of sight of the eye. The loss of sight must be unrecoverable by natural, surgical or artificial means.

"Severance" means the complete separation and dismemberment of the part from the body.

This benefit will be payable in addition to any other benefit payable under this Policy, subject to all the terms and conditions of this Policy.

MANDATED BENEFITS

Mammography Benefit

We will pay the actual expense incurred by a Covered Person for periodic mammography examinations on the following schedule:

1. One mammogram per year for a woman who is at risk for breast cancer;
2. A baseline mammogram for any woman 35 through 39 years of age;
3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
4. A mammogram every year for any woman 50 years of age or older.

As used in this benefit, “at risk for breast cancer” means any of the following:

1. The woman has a personal history of breast cancer.
2. The woman has a personal history of biopsy-proven benign breast disease.
3. The woman’s mother, sister, or daughter has or has had breast cancer; or
4. The woman has not given birth prior to age 30.

Cytologic Screening Benefit

We will pay the actual expense incurred by a Covered Person for cytologic screening as described below:

1. an annual cervical cytologic screening for women
2. a Cervical cytologic screening for women upon certification by an attending physician that the test is medically necessary.

This benefit includes coverage for the examination, the laboratory fee, and the physician’s interpretation of the laboratory results.

Home Health Care Benefits

Expenses incurred by a Covered Person for Home Health Care as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Injury or Sickness.

"Home Health Care" means those nursing and other home health care services rendered to a Covered Person who is the patient in his place of residence, under the following conditions:

1. on a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis; and
2. if continuing hospitalization would have been otherwise required if home health care were not provided; and
3. pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health care provider by ownership or contract. All care plans must be established within 14 days following commencement of home health care.

"Home Health Care Provider" means an agency that is licensed as a home health agency.

"Home Health Care Services" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Covered Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this Policy if the Covered Person were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this Policy if performed while the Covered Person was confined in a Hospital as an Inpatient, provided that service is performed as part of the plan of care.

Limitations - Home Health Care Benefits are subject to the following limitations:

1. services must follow a Hospital confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
2. any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.
3. the amount payable for a home health care visit will not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this Policy during the prior Hospital confinement; for each subsequent day of such services, the amount payable will not exceed one-half of the daily room and board benefit provided by this Policy during the prior Hospital confinement.
4. the services and supplies must be furnished and charged for by a Home Health Care Provider.

Payment of this benefit is subject to all other terms and conditions of this Policy.

Preventive And Primary Care Benefit

Expenses incurred by Covered Dependent Children up to 18 years of age for preventive and primary care services as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Injury or sickness.

"Preventive and Primary" care services include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening. Services also include, as recommended by the physician, heredity and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy. Coverage shall include unlimited visits for children up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age.

Chemical Dependency Treatment Benefit

Expenses incurred by a Covered Person for the treatment of chemical dependency will be considered a Covered Expense and will be payable under the Policy to the same extent as any other Covered Expense.

Diabetes Treatment Benefit

Expenses incurred by a Covered Person for the treatment of diabetes will be considered Covered Expenses under the Policy and will be payable to the same extent as any other Covered Expenses.

The treatment of diabetes may include diabetes self-management training and educational services and equipment, supplies, medications, and laboratory procedures used to treat diabetes.

Mastectomy And Reconstructive Breast Surgery Benefit
Expenses incurred by a Covered Person for a Mastectomy and Reconstructive Breast Surgery incident to a Mastectomy will be considered Covered Expenses under the Policy and will be payable to the same extent as any other Covered Expenses.

After a Mastectomy has been performed, any decision made to discharge the Covered Person from the hospital by the attending Physician must be made after consultation with the Covered Person. In addition, such decision must be based on the unique characteristics of each patient taking into consideration the health and medical history of the Covered Person.

Coverage under this section includes coverage for all stages and revisions of reconstructive breast surgery performed on a non-diseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed, as well as coverage 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.

As used in this section, Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

As used in this section, Reconstructive Breast Surgery means surgery performed as a result of a Mastectomy to re-establish 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. This term also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.

Ancillary Dental Care Expense Benefit
Expenses incurred by a Covered Person, as indicated below, for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care, are considered Covered Expenses under the Policy and are payable to the same extent as any other Covered Expense.

This benefit will be payable for a Covered Person who:
1. is 9 years of age or younger or is developmentally disabled; and
2. is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
3. is an individual from whom a superior result can be expected from dental care provided under general anesthesia; or
4. is an extremely uncooperative, fearful or uncommunicative child who is 17 years of age or younger, with dental needs of such magnitude that treatment should not be delayed or deferred; and
5. is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

This section does not provide benefits for the dental care for which the anesthesia is required.

Maternity And Newborn Care Benefit
Expenses incurred by a Covered Person due to pregnancy are considered Covered Expenses under the Policy and are payable the same as any other Covered Expenses.

This benefit includes coverage for up to 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery and up to 96 hours of inpatient hospitalization care after an uncomplicated cesarean section. If the mother and newborn child have a shorter hospital stay than that provided by this subsection, coverage under this benefit shall include one home visit by a qualified provider within 24 hours after hospital discharge. Regardless of the length of the hospital stay, coverage under this benefit includes an additional home visit, if prescribed by the attending physician.

Payment of benefits under this section are subject to the same deductible, co-payment, co-insurance and maximum limits as any other Covered Expenses under the Policy, however, the home visit provided by this section is not subject to the deductible, co-payment or co-insurance provisions.

Osteoporosis Diagnosis And Treatment Benefit
Expenses incurred by a Qualified Individual, for a Bone Mass Measurement which is requested for the prevention, diagnosis, and treatment of osteoporosis are considered Covered Expenses under the Policy and are payable to the same extent as any other Covered Expenses.

As used in this section, the following terms are defined as indicated:

Bone Mass Measurement means a radiologic or radioscopic procedure or other scientifically proven technology performed on a Qualified Individual for the purpose of identifying bone mass or detecting bone loss.

Qualified Individual means a Covered Person who is:
1. An estrogen deficient individual at clinical risk for osteoporosis;

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

Payment of this benefit is subject to all other terms and conditions of the Policy.

Prescription Contraceptives
Expenses incurred for contraceptive drugs or devices are considered Covered Expenses under the Policy and are payable to the same extent as any other drugs provided under the policy. This benefit includes coverage for the insertion or removal and any medically necessary examination associated with the use, of such contraceptive drug or device.

Prostate Cancer Screening Benefit
Expenses incurred by a Covered Person, subject to the limitations described below, for a medically recognized diagnostic examination including a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test are considered Covered Expenses under the Policy and are payable to the same extent as any other Covered Expenses, when such examination is recommended by a Physician.

Payment of this benefit is subject to all other terms and conditions of the Policy.

CONTINUATION OF COVERAGE PRIVILEGE

A student of the Policyholder who has been continuously insured under the Policy for 6 months and no longer meets the eligibility requirements of the Policy may elect to continue coverage for himself for up to 3 months.

Coverage will be identical in scope to the coverage provided in this policy. Within 14 days of becoming no longer eligible for coverage under the Policy, the student must make application and pay premiums directly to the Company or its designated representative. Evidence of Insurability is not required for this continuation of coverage.

A student who exercises this option will not have his coverage interrupted or canceled or otherwise terminated until the date on which:
1. there is a failure to make a premium payment in the time required to make such payment; or
2. the required period for continued coverage ends; or
3. the Policy is terminated.

EXCLUSIONS

Benefits are not payable under this Policy for any of the following or loss that results there from:

1. Routine physical examinations and routine testing; preventive testing or Treatment; screening examinations or testing in the absence of Injury or Sickness.
2. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; eyeglasses, contact lenses or other Treatment for visual defects and problems, except as required as a result of a covered Injury. "Visual defects" means any physical defect of the eye that does or can impair normal vision.
3. Hearing examinations or hearing aids; or other Treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing.
4. Dental care or Treatment other than care of sound, natural teeth and gums required due to an Injury resulting from an Accident while the Covered Person is insured under this Policy, and rendered within 12 months of the Accident.
5. War or any act of war, declared or undeclared; or while serving in the armed forces of any country (a pro-rata premium will be refunded for such period of service).
6. Participation in a riot or civil disorder; fighting or brawling, except in self-defense; commission of or attempt to commit a felony.
7. Suicide, attempted suicide or intentionally self-inflicted Injury while sane or insane.
8. Participation in, practice for, or orthopedic equipment and appliances used for intercollegiate sports, semi-professional sports; or professional sports (except as specified in the Coverage Descriptions).
9. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any type of aircraft, except while riding as a fare-paying passenger on a regularly-scheduled airline.

10. Treatment, services or supplies provided by a Hospital or facility owned or run by the United States Government, unless a charge is made for such services in the absence of insurance; or in a Hospital which does not unconditionally require payment.
11. Cosmetic surgery, except cosmetic surgery which the Covered Person needs as the result of an Accident which happens while he is insured under this Policy.
12. Elective Treatments and voluntary testing.
13. Injury or Sickness covered by Worker's Compensation or Employer's Liability Laws.
14. Treatment or services provided by any member of the Covered Person's immediate family; or for which no charge is normally made.
15. Treatment, services or supplies provided by the School's infirmary or its employees, or Physicians who work for the School, except when the Covered Person is required to pay for such service.
16. Nasal or sinus surgery (unless required due to an Injury resulting from an Accident while the Covered Person is insured under this Policy).
17. Organ transplants.
18. Mental or nervous disorders except as specified in the Schedule of Benefits.
19. Acupuncture.
20. Outpatient treatment for physiotherapy, except for a condition that required surgery or Hospital confinement within 30 days immediately preceding such physiotherapy or within 30 days of the Physician’s release for rehabilitation from such Hospital.
21. The diagnosis and treatment of acne.
22. The diagnosis and treatment of Infertility.
23. Elective abortions.
24. Outpatient prescription drugs except as specified in the Description of Benefits.
25. Supplies, except as otherwise provided in the Policy.
26. Treatment of allergies, including allergy testing.
27. Routine foot care, including the treatment of corns, calluses and bunions.
28. Impotence, whether organic or otherwise.
29. Nonmalignant warts, moles or lesions.
30. Sleeping disorders, including testing thereof.

Pre-existing Conditions Limitation: The Company will not pay benefits for a Pre-Existing Condition. This does not apply if the Covered Person has been insured under the Policy for 12 months.

This limitation applies only to those Covered Persons and Descriptions of Benefits indicated on the Schedule of Benefits.

This limitation does not apply to Newborn, Adopted or Foster Children, covered under the Policy.

Credit for Prior Coverage - A Covered Person, whose coverage under prior Creditable Coverage ended no more than 63 days before coverage under the Policy became effective, will have any applicable pre-existing condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, we will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

1. Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
2. The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
3. The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
4. Chapter 55 of Title 10, United State Code, the Civilian Health and Medical Program of the Uniformed Services;

5. A medical care program of the Indian Health Service or of a tribal organization;
6. A state health benefits risk pool;
7. A health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
8. A public health plan as defined by federal regulations; or
9. A health benefit plan under section 5(e) of the Peace Corps Act.
10. The Health Insurance Program for Children Established in Part 8 of Chapter 108A of the North Carolina General Statutes, or an successor program.

Certificates of Creditable Coverage - We will issue Certificates of Creditable Coverage for each Covered Person whose coverage under the Policy is terminated. Such issuance will occur within a reasonable time. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy (including any endorsement or amendments), the signed application of the Policyholder (a copy of which will be attached to this Policy at issue), and the individual applications of Covered Persons, if any, constitute the entire contract. All statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement will void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application. To be valid, any change or waiver must be in writing, must be signed by our President or Secretary and must be attached to this Policy. No agent has authority to change this Policy or to waive any part of this Policy.

CLERICAL ERROR: If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the terms of this Policy.

EXAMINATION OF RECORDS AND AUDIT: The Company will be permitted to examine and audit the Policyholder's books and records at any time during the Policy Term and within two years after the final termination of this Policy, insofar as they relate to premium or subject matter of this insurance.

CONFORMITY WITH STATE LAWS: On the effective date of this Policy, any provision that is in conflict with laws in the state in which it is issued is amended to conform to the minimum requirements of such laws.

NOT IN LIEU OF WORKERS' COMPENSATION: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

GRACE PERIOD: A grace period of 31 days is granted for the payment of each premium due after the first premium, during which time the Policy continues in force. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

POLICY TERMINATION: The Policy will continue in force while the required premiums are paid until either the Company or the Policyholder terminates the policy. At least 45 days advance written notice is required to terminate this Policy by either party.

CERTIFICATES: When required by applicable law, the Company will issue to the Policyholder, for delivery to each Covered Person, a certificate containing the principal terms of this Policy.

CLAIM PROVISIONS

NOTICE OF CLAIM: A claimant must give the Company or our authorized representative written notice of claim within 90 days after the date any loss occurs which is covered by this Policy. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person and the Policy Number.

CLAIM FORMS: Upon receiving written notice of claim, the Company will send claim forms to the claimant within fifteen days. If the Company does not furnish such forms, the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

WRITTEN PROOF OF LOSS: Written proof of loss must be sent to the agent authorized to receive it. Written proof must be given within 180 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity should proof of loss be sent later than one year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS: When the Company receives written proof of loss, any benefits due will be paid.

PAYMENT OF CLAIMS: If the Covered Person dies, any death benefits or other benefits unpaid at the time of death of the Covered Person will be paid to the beneficiary. If no beneficiary is on record with the Company or our authorized agent, payment will be made to the estate of the Covered Person. All other benefits will be paid to the Covered Person. If the Covered Person is (1) a minor; or (2) in our opinion, unable to give a valid release because of incompetence, we may pay any amount due to a parent, guardian, or other person actually supporting him. Any payment made in good faith will end our liability to the extent of the payment.

BENEFICIARY: The Covered Person may designate a beneficiary and he has the right to change the beneficiary at any time by written notice. If the Covered Person is a minor, his parent or guardian may exercise this right for him. If changed, the new beneficiary designation will be effective when the Company or the Administrator receives it. When received, the effective date is the date the notice was signed. The Company is not liable for any payments made by the Company before the change was received. The Company cannot attest to the validity of a change.

ASSIGNMENT: At the request of the Covered Person or his parent or guardian, medical benefits may be paid to the provider of these services. Any payment made in good faith will end our liability to the extent of the payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company has the right to have a Physician of our choice examine the Covered Person as often as is reasonably necessary. This section applies while a claim is pending or while benefits are being paid. The Company also has the right to request an autopsy in case of death, unless the law forbids it. The Company will pay the cost of any examination or autopsy.

LEGAL ACTIONS: No lawsuit or action in equity can be brought to recover on this Policy: (1) before 60 days following the date proof of loss was furnished to the Company; (2) after three years following the date proof of loss is required.

BCS Insurance Company

AMENDATORY RIDER

This rider amends the policy and any applicable certificate to which it is attached, and takes effect and expires concurrently with the policy.

I. The Part titled **EXCLUSIONS** is hereby amended as follows:

Exclusion 3, related to hearing examinations, is hereby deleted and replaced with the following:

3. Hearing examinations or hearing aids; or other Treatment for hearing defects and problems, except as required as a result of a covered injury. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing.

II. The item titled **Cytologic Screening Benefit** in the section **MANDATED BENEFITS** is replaced in its entirety by the following:

Cervical Cancer Screening Benefit
We will pay, subject to the same terms and conditions as an Accident or Sickness covered under this policy (including the application of deductible amounts, benefit percentages, and benefit maximums), the Usual and Customary charges incurred by a Covered Person for examinations and laboratory tests for the early detection of cervical cancer as described below:

1. conventional PAP smear screening,
2. liquid based cytology, and
3. 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.

Coverage for the screening for the early detection of cervical cancer 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. This benefit includes coverage for the examination, the laboratory fee, and the physician's interpretation of the results. Laboratory fees are only eligible the laboratory meets the accreditation standards adopted by the North Carolina Medical Care Commission.

III. The following item is added to the section titled **MANDATED BENEFITS:**

OVARIAN CANCER SCREENING BENEFIT

Expenses incurred, by a Covered Person age 25 or older who is at risk for ovarian cancer, for surveillance tests will be considered Covered Expenses and will be payable under the Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Sickness.

"At risk for ovarian cancer" means either:

1. having a family history (a) with one or more first degree relatives with ovarian cancer, and (b) a second relative, either first degree or second degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
2. testing positive for hereditary ovarian cancer syndrome.

"Surveillance Tests" means annual screening using:

1. transvaginal ultrasound, and
2. rectovaginal pelvic examination.

Nothing contained in this rider will alter, waive or extend the provisions, conditions or limitations of the policy, except as expressly stated above.

Signed for the BCS Insurance Company.

H F Bleckham, III
PRESIDENT