



University of North Carolina Schools – International Students

CERTIFICATE OF COVERAGE

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. U-1051-08 (“the Policy”)

Participating Organization or Institution:	University of North Carolina Schools
Participating Organization’s or Institution’s Effective Date:	August 1, 2008
Eligible Participant:	See Identification Card Issued to Participant
Eligible Dependents:	See Identification Card Issued to Participant
Coverage Start Date:	See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a “Covered Person,” and to UniCare Life & Health Insurance Company as “Insurer.” The Policy will be administered on behalf of the Insurer by “the Administrator:” **HTH Worldwide Insurance.**

This Certificate replaces all certificates previously issued to the Eligible Participant as evidence of coverage under the Policy.

READ YOUR CERTIFICATE CAREFULLY.



David W. Fills
President

**IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE SECTION ENTITLED
“ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE”**

THIS CERTIFICATE CONTAINS A PRE-EXISTING CONDITION LIMITATION

EXCESS INSURANCE

This 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 benefit payable by such other medical insurance will become the deductible amount of this policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

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SECTION 1 SCHEDULE OF BENEFITS ELIGIBLE CLASSES

The Classes eligible for coverages available under the Policy are shown below. The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.

- Class I: All regular, full-time Eligible Participants of the educational organization or institution.
- Class II: All part-time Eligible Participants of the educational organization or institution and their Eligible Dependents.
- Class III: Mandatory - Eligible Participants.
- Class IV: Voluntary - Eligible Dependents - Spouse.
- Class V: Voluntary - Eligible Dependents - Child.

All benefits and limits are stated per Covered Person

SCHEDULE OF BENEFITS – TABLE 1

	Limits Eligible Participant	Limits Spouse	Limits Child
COVERAGE A – MEDICAL EXPENSES			
Maximum Benefit per Injury or Sicknesses	\$150,000	\$50,000	\$50,000
Basic Medical Expense Benefit per Injury or Sickness	Up to \$10,000 Maximum: 100% of Reasonable Expenses after Deductible	Up to \$10,000 Maximum: 100% of Reasonable Expenses after Deductible	Up to \$10,000 Maximum: 100% of Reasonable Expenses after Deductible
Supplemental Major Medical Expense Benefit (SMM) per Injury or Sickness	After Basic Medical Expense Benefit Maximum has been paid, 80% of Reasonable Expenses up to an additional \$40,000 Maximum	After Basic Medical Expense Benefit Maximum has been paid, 80% of Reasonable Expenses up to an additional \$40,000 Maximum	After Basic Medical Expense Benefit Maximum has been paid, 80% of Reasonable Expenses up to an additional \$40,000 Maximum
Catastrophic Major Medical Expense Benefit (CMM) per Injury or Sickness	After both Basic Medical Expense Benefit Maximum and the Supplemental Major Medical Benefit Maximums have been paid, 100% of Reasonable Expenses up to an additional \$100,000 Maximum	Not Covered	Not Covered
Deductible (Deductible is reduced to \$0 if treatment is received at Recognized Student Health Center or if initial treatment is received at Recognized Student Health Center.)	\$100 per Injury or Sickness	\$100 per Injury or Sickness	\$100 per Injury or Sickness
COVERAGE B – ACCIDENTAL, DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$10,000	Maximum Benefit: Principal Sum up to \$5,000	Maximum Benefit: Principal Sum up to \$1,000
COVERAGE C – REPATRIATION OF REMAINS	Maximum Benefit up to \$15,000	Maximum Benefit up to \$15,000	Maximum Benefit up to \$15,000
COVERAGE D – MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to \$50,000	Maximum Lifetime Benefit for all Evacuations up to \$50,000	Maximum Lifetime Benefit for all Evacuations up to \$50,000

**SCHEDULE OF BENEFITS – TABLE 2
COVERAGE A – MEDICAL EXPENSES**

	Indemnity Plan Limits
Physician Office Visits*	For Basic, after Deductible, 100% of Reasonable Expenses. For SMM Benefit, after Deductible, 80% of Reasonable Expenses. For CMM, after Deductible, 100% of Reasonable Expenses.
Inpatient Hospital Services Maximum payment for Intensive Care Facility up to \$1,000 per day	For Basic, after Deductible, 100% of Reasonable Expenses. For SMM Benefit, after Deductible, 80% of Reasonable Expenses. For CMM, after Deductible, 100% of Reasonable Expenses.
Hospital and Physician Outpatient Services	For Basic, after Deductible, 100% of Reasonable Expenses. For SMM Benefit, after Deductible, 80% of Reasonable Expenses. For CMM, after Deductible, 100% of Reasonable Expenses.

*All Physician Visit Deductible for an Injury or Sickness are waived if treatment is received at Recognized Student Health Center or if the initial treatment for an Injury or Sickness is received at Recognized Student Health Center.

**SCHEDULE OF BENEFITS – TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

1. TABLE 1 LIFETIME MAXIMUMS, ANNUAL MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;
2. TABLE 1 LEVELS OF COVERAGE FOR BASIC MEDICAL EXPENSE BENEFITS, SUPPLEMENTAL MAJOR MEDICAL EXPENSE BENEFITS, AND CATASTROPHIC MAJOR MEDICAL EXPENSE BENEFITS; AND
3. TABLE 2 PLAN TYPE LIMITS (INDEMNITY OR PPO)

MEDICAL EXPENSE	Limits – Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$5,000 Maximum per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$500 Maximum per lifetime
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses on an Inpatient basis. Reasonable Expenses up to \$45 Maximum per visit subject to a Maximum of 20 visits on an Outpatient basis. This benefit is per Policy Year.
Therapeutic or Elective termination of pregnancy	Reasonable Expenses up to \$500 Maximum per Policy Year
Professional ground or air ambulance service to nearest hospital	Reasonable Expenses up to \$350 per Injury or Sickness
Medical treatment arising from participation in intercollegiate, interscholastic, intramural or club sports	Reasonable Expenses up to \$5,000 Maximum per Policy Year.
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$250 per tooth per Injury
Dental Treatment (including extractions) to alleviate pain	100% of Reasonable Expenses up to \$500 per lifetime
Outpatient prescription drugs	80% of actual charge

SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES

- A. **What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Policy due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit of \$150,000 per Injury or Sickness for the Eligible Participant or the Maximum Benefit of \$50,000 per Injury or Sickness for an Eligible Dependent. Benefits are subject to the Deductible Amount, Coinsurance and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-Existing Condition Limitation, the Recognized Student Health Center provision and to all other limitations and provisions of the Policy.
- B. **Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Reasonable Expenses incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group policy administered by the Administrator immediately prior to the Policy Effective Date, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance.

1. **Physician office visits.**

2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; x-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

3. **Recognized Student Health Centers:** If there is a charge for visits to, or medical services, treatments and supplies received from, a Recognized Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at 100% of Reasonable Expenses with no Copayment or Deductible.

If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a provider (if available) included on the Administrator's list provided to the Recognized Student Health Center.

- C. **Additional Covered General Medical Expenses and Limitations:** These additional Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

1. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
- a) a minimum of 48 hours of inpatient care following a vaginal delivery; or
 - b) a minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a) Parental education;
- b) Assistance and training in breast or bottle feeding; and
- c) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

2. **Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.
 3. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
 - a) female Covered Persons are allowed one baseline mammogram;
 - b) female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.);
 4. **Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.
 5. **Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.
 6. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.
 7. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:
 1. Reconstruction of the breast on which the mastectomy has been performed;
 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 3. Prostheses; and
 4. Treatment for physical complications of all stages of mastectomy, including lymphedemas.
- D. **Basic Medical Expense Benefit (Basic):** The Insurer will pay the provider 100% of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A. The Basic Medical Expense Deductible Amount will be reduced to as stated in the Schedule of Benefits if initial treatment is rendered at the Participant's Registered Student Health Center.
- E. **Supplemental Major Medical Expense Benefit (SMM):** The Insurer will pay the provider 80% of all additional Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit.
- F. **Catastrophic Major Medical Expense Benefit (CMM):** The Insurer will pay the provider 100% of all Covered Medical Expenses, unless otherwise stated, which are in excess of the Deductible Amount shown in the Schedule of Benefits for Coverage A and after all benefits have been exhausted under the Basic Medical Expense Benefit and Supplemental Major Medical Expense Benefit.

SECTION 3 COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

SECTION 4
COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the repatriation of the Covered Person's remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body or visitation or funeral expenses. Any expenses for repatriation of remains require the Insurer's or the Administrator's prior approval.

If an Injury or a Sickness results in the Covered Person's loss of life outside his/her Home Country, the Insurer will pay the Reasonable Expense incurred for cremation or for preparation of the body for burial in, and for transportation of the body to, the Home Country up to the maximum stated for this benefit in Table 1 of the Schedule of Benefits. Payment of this benefit is subject to the Limitations and Conditions on Eligibility for Benefits. No benefit is payable if the death occurs after the Period of Coverage Termination Date. However, if the Covered Person is Hospital Confined on the Period of Coverage Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Period of Coverage Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by either the Insurer or the Administrator before the body is prepared for transportation.

SECTION 5
COVERAGE D – MEDICAL EVACUATION BENEFIT

If a Covered Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to the lifetime Maximum Limit for all medical evacuations shown in Table 1 of the Schedule of Benefits, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Covered Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Physician that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or the Administrator's prior approval. No benefits are payable under any other provision of the Policy for expense incurred by the Covered Person on and after the date of the evacuation.

With respect to this provision only, the following is in lieu of the Policy's Extension of Benefits provision: No benefits are payable for Reasonable Expenses incurred after the date the Covered Person's insurance under the Policy terminates. However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.

SECTION 6
PRE-EXISTING CONDITION LIMITATION

The Policy does not pay benefits for loss due to a Pre-Existing Condition during the first one (1) year of coverage, except as follows: The Policy will pay for Covered Medical Expenses incurred in connection with a Covered Person's Pre-Existing Condition during the first one (1) year of coverage, subject to a maximum benefit of \$2,500. After the Covered Person has been covered under the Policy for one (1) year, Pre-Existing Conditions will be covered the same as any other Injury or Sickness.

This limitation does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.

SECTION 7
GENERAL POLICY EXCLUSIONS

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health.
2. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
3. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
4. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
5. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
6. Expenses incurred in excess of Reasonable Expenses.
7. Expenses incurred for Injury resulting from the Covered Person's being legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the Accident occurs. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
8. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit.
9. Organ or tissue transplant.
10. Participating in an illegal occupation or committing or attempting to commit a felony.

11. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
12. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
13. Expenses incurred within the Covered Person's Home Country.
14. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.
15. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
16. Diagnosis and treatment of acne and sebaceous cyst.
17. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
18. Intentionally self-inflicted Injuries while sane or insane; suicide, or any attempt thereat while sane or insane. This exclusion does not apply to the Medical Evacuation Benefit and to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
19. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; civil commotion.
20. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
21. Loss arising from participation in professional sports, scuba diving, hang gliding, parachuting or bungee jumping.
22. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
23. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

SECTION 8 DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Policy, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Age means the Covered Person's attained age.

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Reasonable Expenses for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.

Country of Assignment means the country for which the Eligible Participant has a valid passport and, if required, a visa, and in which he/she is undertaking an educational activity.

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

1. administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. are not excluded by any provision of the Policy; and incurred while the Covered Person's insurance is in force under the Policy, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 2.

Covered Person means an Eligible Participant and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Policy.

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or per Sickness basis before certain benefits are payable under the Policy. The Deductible Amounts are stated in the Schedule of Benefits.

Durable Medical Equipment means medical equipment which:

1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse and/or his/her unmarried children under age 19 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who

1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Eligible Participant's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care:

1. That is provided for an Injury or a Sickness caused by the sudden, unexpected onset of a medical condition with acute symptoms of sufficient severity and pain to require immediate medical care; and
2. In the absence of which one could reasonably expect that one or more of the following would occur:
 - a. The Covered Person's health would be placed in serious jeopardy.
 - b. There would be serious impairment of the Covered Person's bodily functions.
 - c. There would be serious dysfunction of any of the Covered Person's bodily organs or parts.

Experimental or Investigational means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is experimental or investigational.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.

Hospital means a facility that:

1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

Immediate Family means the spouse, children, brothers, sisters or parents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Policy. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Medically Necessary means medical and dental service, treatment or supplies which are:

1. Recommended by the attending Physician;
2. Consistent with generally accepted medical practice for the Injury or Sickness, as determined by the Insurer;
3. Generally considered by Physicians in the United States of America or as determined by the Administrator as prevailing in the geographic locality where and at the time the service or supply is rendered to be appropriate for the Injury or Sickness; and
4. Accepted as safe, effective and reliable by a medical specialty or board recognized by the American Board of Medical Specialties or as determined by the Administrator as prevailing in the geographic locality where and at the time the service or supply is rendered.

A medical or dental treatment will not be deemed Medically Necessary if the Insurer determines that any service, supply or treatment used or provided in connection with the Injury or Sickness is Experimental or Investigational in nature. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary. If services do not meet the criteria above or are not consistent with professionally recognized standards of care with respect to quality, frequency or duration, such services will not be deemed Medically Necessary.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Participating Organization or Institution means the organization or institution which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Policy and which has been accepted by the Insurer for coverage under the Policy.

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

Policy Year means the period beginning on the Participating Organization's or Institution's effective date. It includes the period beginning on the date a Covered Person's coverage under the Policy starts. It ends on the date the Covered Person's insurance under the Policy ends.

Pre-Existing Condition means any Injury or Sickness which had its origin or symptoms, or for which a Physician was consulted or for which treatment or a medication was recommended or received up to one (1) year prior to the Covered Person's effective date of coverage.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students for a minimum of 10 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider.

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after his/her name.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Policy.

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
 - a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
 - b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

Written Request means a request on any form provided by the Administrator for particular information.

11:59:59 p.m. means 11:59:59 p.m. at the Covered Person's location.

12:00:01 a.m. means 12:00:01 Eastern Prevailing Time in Washington, DC.

SECTION 9 EXTENSION OF BENEFITS

No benefits are payable for medical treatment benefits after the Covered Person's insurance terminates. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

SECTION 10 EXCESS COVERAGE

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies.

SECTION 11 ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Eligible Participant: Eligible Participant means any person who satisfies the definition of an Eligible Participant and the requirement of an applicable class as shown in Section 1—Eligible Classes. He/she must not be insured under the Policy as a dependent. When both spouses are insured as Eligible Participants under the Policy, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: An Eligible Participant will be eligible for coverage under the Policy subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Policyholder, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date shown on the Insurance Identification Card, if any;
4. The date the requirements in Section 1—Eligible Classes are met; or
5. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Group which also has coverage under the same policy form, or transfers from one plan to another under the same policy, and coverage is continuous, then coverage is continued between the two plans of insurance. A Covered Person will be covered under the newer plan for medical conditions which first arise on or after the transfer date. A Pre-Existing Condition will not be covered under the newer plan until the benefit period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Pre-Existing Condition will be covered under the newer plan. Benefit payments for Pre-Existing Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

Both 1 and 2 above are subject to the benefit periods, deductibles, and Coinsurance as defined in the respective policies.

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The Participating Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form, if any, including any requested extension;
5. The date the Eligible Person leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage, less any administrative fees. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligibl.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

When an Eligible Dependent's Coverage Starts: An Eligible Dependent's coverage starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or
2. The Participating Organization's or Institution's Effective Date;
3. The effective date of the Eligible Participant's insurance;
4. The effective date shown on the insurance identification card, if any;
5. The date the eligibility requirements in this section are met; or
6. The date the completed enrollment form, if any, and premium are received by the Insurer. Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates; or
2. The Participating Organization's or Institution's Termination Date;
3. The date the Eligible Participant is no longer covered under the Policy;
4. The end of the term of coverage shown on the enrollment form, if any, including any requested extension;
5. 11:59:59 p.m. on the date he or she departs the Country of Assignment for his or her Home Country;
6. The date the Covered Person requests cancellation of coverage (the request must be in writing);
7. The premium due date for which the required premium has not been paid, or
8. The date on which the dependent ceases to meet the eligibility requirements.

Coverage will end at 11:59:59 p.m. on the last date of insurance. A dependent's coverage will end without prejudice to any claim.

SECTION 12 COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits.

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement for adoption, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.

In order to continue the coverage of a newborn child beyond the 31st day following his/her date of birth or of an adopted child beyond the 31st day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.

SECTION 13 CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Policy must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Policy by submitting, within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer are liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Policy which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to \$1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Policy and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

SECTION 14 GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Participating Organization or Institution, a copy of which are attached to and made a part of the Policy. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person's insurance will not be contested except for nonpayment of premium, after his/her insurance under the Policy has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Policy unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

Time Limit on Certain Defenses: No claim for loss incurred after 2 years from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Policy.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Policy does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Policy due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Policy in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

In accordance with state insurance law, this certificate is composed of the following forms on file with the State Insurance Department.

Certificate	BCR 100 03/03
Schedule of Benefits – Eligibility Classes	BCR 130 03/03
Schedule of Benefits – Table 1	BCR 131 03/03
Schedule of Benefits – Table 2	BCR 132 03/03
Schedule of Benefits – Table 3	BCR 133 03/03
Description of Coverages – Medical Expenses	BCR 360 03/03
Accidental Death and Dismemberment Benefit	BCR 210 03/03
Repatriation of Remains Benefit	BCR 140 03/03
Medical Evacuation Benefit	BCR 141 03/03
Pre-Existing Condition Limitation	BCR 361 03/03
General Policy Exclusions	BCR 143 03/03
Definitions	BCR 110 03/03
Extension of Benefits	BCR 144 03/03
Excess Coverage	BCR 146 03/03
Eligibility Requirements and Period of Coverage	BCR 120 03/03
Coverage of Newborn Infants and Adopted Children	BCR 147 03/03
Claim Provisions	BCR 171 03/03
General Provisions	BCR 172 03/03

Administered by:
Worldwide Insurance Services, Inc.
One Radnor Corporate Center, Suite 100
Radnor, PA 19087
Customer Service: 1.888.350.2002

UniCare Life & Health Insurance Company

233 S. Wacker Drive, Suite 3900
Chicago, Illinois 60606

Endorsement to Policy/Certificate State of North Carolina

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such policy/certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the policy/certificate is amended, with respect to Covered Persons residing in the state of North Carolina, as follows:

1. The Mammography and Annual cervical cytology provisions in Section 2, Description of Coverages, are deleted in their entirety, and replaced with the following provision:

Mammography examinations and Cervical Cancer Screening tests: Coverage shall be provided for mammography examinations for the presence of occult breast cancer and examinations and laboratory tests for the screening for early detection of cervical cancer.

Coverage for routine mammography screenings will be limited to the following:

1. one or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. A woman is at risk for breast cancer if any one of more of the following is true:
 - a. the woman has a personal history of breast cancer;
 - b. the woman has a personal history of biopsy-proven benign breast disease;
 - c. the woman's mother, sister, or daughter has or has had breast cancer; or
 - d. the woman has not given birth prior to the age of 30;
2. one baseline mammogram for any woman 35 through 39 years of age, inclusive;
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.

Coverage for Cervical Cancer Screenings will include conventional PAP Smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration. Coverage will include the examination, the laboratory fee, and the Physician's interpretation of the laboratory results.

2. Section 2, Description of Coverages, is amended to include the following Covered Medical Expenses:

- a. **Reconstructive Surgery Following Mastectomy:** The coverage provided for reconstructive breast surgery following a mastectomy is amended to include reconstruction of the nipple/areolar complex following a mastectomy without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating Physician.
- b. **Contraceptives:** Coverage shall be provided for prescription contraceptive drugs or devices, including the insertion or removal of and any Medically Necessary examination associated with the use of the prescribed contraceptive drug or device.
- c. **Osteoporosis/Bone Mass Measurement:** Coverage shall be provided for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass.

Bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that coverage for follow-up bone mass measurement performed more frequently than every 23 months shall be covered if the follow-up measurement is medically necessary.

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

- d. **Newborn Hearing Screening:** Coverage shall be provided for a newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. Such benefit shall be subject to the same terms and conditions applicable to all other benefits under the Policy.
- e. **Clinical Trials:** Coverage shall be provided for participation in phase II, phase III, and phase IV clinical trials by Covered Persons who meet protocol requirements of the trials and provide informed consent. As used here, "Covered clinical trials" means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:
 1. involve the treatment of life-threatening medical conditions;
 2. are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives; and
 3. have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:

- (a) Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
 - (b) Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities; and
 - (c) Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.
- f. **Anesthesia and Hospitalization for Dental Procedures:** Coverage shall be provided for payment of anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of 9 years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.
- g. **Complications of Pregnancy:** Coverage shall be provided for complications of pregnancy. As used here, complications of pregnancy means conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompression, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include termination of ectopic pregnancy, an emergency (non-elective) cesarean section, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.
- h. **Surveillance tests for ovarian cancer:** Coverage shall be provided for surveillance tests for women age 25 and older at risk for ovarian cancer. As used in this covered services:
- 1 "At risk for ovarian cancer" means either:
 - a. Having a family history:
 - 1. With at least one first-degree relative with ovarian cancer; and
 - 2. A second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
 - b. Testing positive for a hereditary ovarian cancer syndrome.
 - 2 "Surveillance tests" mean annual screening using:
 - a. Transvaginal ultrasound; and
 - b. Rectovaginal pelvic examination.
3. Section 6, Pre-Existing Condition Limitation, is amended to provide that this limitation will not apply to any dependent child adopted by an Eligible Participant, or placed with an Eligible Participant for adoption, if the adoption or placement for adoption occurs while the Eligible Participant is eligible for coverage under the Policy.

The Pre-Existing Condition Limitation is also amended to include a credit for the time a Covered Person was covered by Creditable Coverage that was in effect not more than 63 days before the Covered Person's effective date under the Policy. As used here, Creditable Coverage means coverage provided under:

- a. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 101 et seq.);
 - b. a group health benefit plan provided by a health insurance carrier or health maintenance organization;
 - c. an individual health insurance policy or evidence of coverage;
 - d. Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
 - e. Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
 - f. Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
 - g. A medical program of the Indian Health Service or of a tribal organization;
 - h. A state health benefits risk pool;
 - i. A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);
 - j. A public health plan as defined by federal regulations;
 - k. A health benefit plan under Section 5 (e), Peace Corps Act (22 U.S.C. Section 2504(e)).
 - l. The Health Insurance Program for children established in Part 8 of Chapter 108A of the General Statutes, or any successor program.
4. Section 7, General Policy Exclusions are revised as follows:
- a. Exclusion 5 is hereby deleted in its entirety and replaced with the following:
 - 5. For diagnostic investigation or medical treatment for infertility, fertility.
 - b. Exclusion 7 is hereby deleted in its entirety.
 - c. Exclusion 12 is hereby deleted in its entirety and replaced with the following:

12. The diagnosis or treatment of Congenital Conditions, except for a newborn, foster, or adopted child while insured under the Policy.

d. Exclusion 14 is hereby deleted in its entirety and replaced with the following:

14. Treatment to the teeth and gums, including surgical extractions of teeth.

5. The definition of "Eligible Dependent", Section 8, Definitions, is amended to include foster children.

6. Section 8, Definitions, is amended to include the following definitions.

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

- a. placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- b. Serious impairment to bodily functions.
- c. Serious dysfunction of any bodily organ or part.

Emergency Services means health care items and services furnished or required to screen or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

7. The definition of "Medically Necessary", Section 8, Definitions, is deleted in its entirety and replaced with the following definition:

Medically Necessary means services or supplies which are provided for the diagnosis, treatment, relief or cure of a disease, Injury, illness, or health condition and which satisfy all of the following:

- a. it is not for experimental, investigational, or cosmetic purposes; and
- b. it is necessary for and appropriate to the diagnosis, treatment, relief or cure of disease, Injury, illness, health condition or its symptoms; and
- c. it is consistent with recognized standards which are generally accepted by the United States medical community as effective for diagnosis, relief, cure or treatment; and
- d. it is not provided solely for the convenience of an insured, family member, or provider.

The definition of "**Total Disability or Totally Disabled**", Section 8, Definitions, is amended to state that a totally disabled person will not be required to be under the regular care of a Physician if such person has reached his maximum point of recovery.

8. The When An Eligible Dependent's Coverage Ends provision, Section 11, Eligibility Requirements And Period of Coverage, is amended to include the following:

Attainment of the limiting age shall not operate to terminate the coverage of an Eligible Dependent child if at such date the Dependent child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap and (2) chiefly dependent upon the Eligible Participant for support and maintenance.

Proof of the incapacity and dependency shall be furnished to the Insurer by the Eligible Participant within 31 days of the child's attainment of the limiting age. The Insurer may require proof of the child's continuing incapacity and dependency, but no more frequently than once every year after the child's attainment of the limiting age.

9. Section 12, Coverage of Newborn Infants And Adopted Children, is amended to read as follows:

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person from the moment of his/her birth if the birth occurs while the Policy is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits.

Coverage of Adopted and Foster Children: An adopted child or a foster child of the Eligible Participant is covered on the same basis as a newborn. Coverage starts on date of placement in the foster home, provided the Eligible Participant's coverage is then in force.

If additional monthly premiums will be required to cover a new dependent child, the Eligible Participant must provide written notice within 31 days of acquiring the new dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. If no additional monthly premium will be required when the Eligible Participant adds a dependent child to the plan, the Eligible Participant should provide written notice so that the Insurer may send an identification card to facilitate the child's access to Covered Medical Services.

Newborn, adopted and foster children shall be covered for the medically necessary treatment of congenital defects or anomalies, including, but not limited to, treatment and care needed by individuals born with cleft lip or cleft palate.

10. In the Proofs of Loss provision, Section 13, the 90 day period is changed to read 180 days.

11. The Time For Payment Of Claim provision, Section 13, Claims Provisions, is hereby deleted in its entirety and replaced with the following:

Benefits payable under the Policy will be paid immediately, but not later than 30 days, after receipt of written proof of loss, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss. If the Insurer determines that a benefit is to be denied, notice of such denial, including the reasons for such denial, shall be provided not later than 30 days after receipt of written proof of loss.

12. Section 13, Claims Provisions, is amended to include the following provision:

Authority to Determine Benefits: The Insurer reserves the right and authority to interpret and determine benefits under the Policy. The fact that a Physician may prescribe, order, recommend, or approve a service or supply, does not, of itself, make the service or supply a Medically Necessary Covered service.

13. The Subrogation provision found in Section 14, General Provision, is hereby deleted in its entirety.

14. Section 14, General Provisions, is hereby amended by the addition of the following provision:

Grievance Procedures

The grievance procedures under this provision are optional and voluntary. A Covered Person may also contact the Department of Insurance for assistance at 430 N. Salisbury Street, Raleigh, North Carolina 27611, or at their consumer toll-free number, 1-800-546-5664.

The grievance procedure is available for review of any policy, decision or action of the Insurer that affects the Covered Person.

Under these grievance procedures, the term "Covered Person" means a Covered Person or a designated representative, including a provider.

Informal Grievance Review

The Covered Person may request an informal review of a grievance. To do so, the Covered Person must contact the insurer's customer service unit. The toll-free number for the customer service unit is provided on the Covered Person's ID card. The informal review will be rendered within 10 business days of contacting the customer service unit. If the decision is not rendered within 10 business days, or if the decision is adverse to the Covered Person, the informal grievance will be rolled into the First-Level Grievance procedure.

First-Level (Formal) Grievance Review

The Covered Person may request a formal review of the grievance by submitting the grievance in writing. The customer service unit listed on the ID card will provide the required forms and the address for mailing the written grievance.

A written acknowledgment will be mailed within 3 working days after receipt of the written grievance. The acknowledgment will contain the name and contact information of a grievance coordinator, and the instructions for submitting additional written material. The Covered Person will be contacted if further information is required.

The review will be conducted by a person not involved with the initial decision. In the event the issue is a clinical one, at least one person reviewing the grievance will be a provider with appropriate expertise to evaluate the matter. The Covered Person does not have the right to attend this review.

The Covered Person has a right to a written decision within 30 calendar days of the receipt of a complete grievance request.

The decision will be written in clear terms and will include the reasons, policies, and procedures upon which the decision was based. It will also advise the Covered Person of any rights to a second-level review and the procedures for submitting a second-level review.

Second-Level (Formal) Grievance Review

The Covered Person may request a review of a first-level grievance decision by submitting the request in writing. The customer service unit listed on the ID card will provide the required forms and the address for mailing the written request.

Within 10 working days after the receipt of the request for review, the Covered Person will be notified of the name and contact information for a grievance coordinator, and of the following rights:

1. to request and receive all information relevant to the case;
2. to attend the review, or present or have a designated representative present, the case to a review panel;
3. to submit information prior to and at the meeting of the review panel;
4. ask questions of the members of the review panel, and be represented or assisted by any person chosen by the Covered Person.

A review panel will convene for each second-level review. The panel will comprise persons who were not previously involved with the decision, and that have no financial interest in the outcome of the review. A review panel meeting will be held within 45 days after receipt of a complete request for a review. The Covered Person will be notified of the meeting at least 15 days prior to the date of the meeting. The review panel's decision will not be conditioned on the attendance of the Covered Person at the meeting.

The Covered Person has a right to a written decision within 7 business days after the review panel meeting. The decision will be written in clear terms and will include the reasons, policies, and procedures that were the basis of the decision. It will also include information of the

Covered Person's right to further remedies allowed by law. The decision made by the Insurer is final. The Commissioner's office is available for assistance at the address and phone number shown above.

Expedited Review

The review meeting will be expedited if completing the review within the standard time frame described above would reasonably appear to seriously jeopardize the life or health of a Covered Person, or jeopardize the Covered Person's ability to regain maximum function. The decision under expedited review will be communicated to the Covered Person or representative of the Covered Person within 4 days of receiving all necessary information.

Availability of Consumer Assistance

For consumer assistance regarding internal review and grievance issues, you may contact:

The Managed Care Patient Assistance Program
Consumer Protection Division
at (919) 733-MCPA (6272)
North Carolina toll-free number is (866) 867-MCPA (6272)
FAX is (919) 733-6276
Or via email at MCPA@ncdoi.com
Mailing address: P.O. Box 629, Raleigh, NC 27602

THIS ENDORSEMENT IS SUBJECT TO ALL PROVISIONS OF THE POLICY/CERTIFICATE NOT INCONSISTENT HEREWITH.



David W. Fildes
President