BENEFIT BOOKLET

FOR THE

COUNTY OF MOORE

CARTHAGE NC

DENTAL PLAN

Effective

07-01-2020

BENEFITS ADMINISTERED BY

WELCOME

This Benefit Booklet describes the benefits available to you under the dental plan sponsored by the County of Moore (the "Employer") for eligible employees of the Employer (and any related companies of the Employer who participate in the dental plan) and their eligible dependents. Please read this Benefit Booklet carefully to become familiar with your benefits.

The County of Moore Dental Plan (the "Plan") is a self-funded plan, which means that the benefits are paid from the Employer's general assets. The Employer has retained FirstCarolinaCare Insurance Company ("FCC") to administer certain aspects of the Plan on its behalf.

The terms "you" and "your" throughout this booklet refer to an employee who is eligible to participate in the Plan and who is enrolled in the Plan, except where otherwise indicated.

IMPORTANT TELEPHONE NUMBERS

Member Services
For questions relating to benefits, to make claims inquiries, or to request a new ID card, call Member Services at**: 800-811-3298 (toll free)**

FCC - Main Office
For any additional questions or information, call: **800-574-8556 (toll free) or 910-715-8100**

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DEFINITIONS

The following definitions apply to the terms used in this Benefit Booklet. These definitions do not imply coverage under the Plan.

Actively Working - performing all of the substantial and material duties of the employee's regular employment or occupation at his/her usual place of employment or an alternative location to which the employee's job requires him/her to travel. An employee will be considered to be Actively working on a weekend day, sick day, vacation/PTO day or holiday if he/she was actively working on the last day he/she was regularly scheduled to work immediately prior to such day.

Annual Enrollment Period - the period of time given by the Plan Administrator each year during which Plan enrollment changes may be made.

Claim - a request for payment for Covered Dental Services.

Continuation Coverage - group dental coverage that may be continued under federal or state law under specified terms and conditions when certain qualifying events occur.

Cosmetic Services - services done primarily to improve the appearance of teeth and not to improve function, including bleaching and cosmetic veneers.

Covered Dental Services - Dental Services that are Medically Necessary and meet all the conditions for coverage described in this Benefit Booklet.

Deductible - an amount of money that must be paid by the Member for Covered Dental Services before the Plan starts paying benefits. The Deductible is shown in the Schedule of Benefits.

Dental Services - professional services for the diagnosis and treatment of disease or defects, or accidental Injury to the teeth, gums, jaws and associated structures, and the alveolar processes. Dental Services include examinations, and consultations, oral surgery and hospitalization for dental related care.

Eligibility Date - the date when a person meets all requirements for coverage and may enroll as a participant in the Plan. For new hires, the Eligibility Date is the Eligible Employee's date of hire.

Eligible Dependent – an individual who resides in the United States and is either:

- Your legal Spouse, but it does not include an individual from whom you have obtained a legal separation or divorce; or

- Your child who is under age 26 and is either:
    - a natural biological or adopted child of the Eligible Employee or a child placed with the Eligible Employee for adoption;
    - a stepchild of the Eligible Employee;
    - a child for whom the Eligible Employee (or the Eligible Employee's spouse) serves as legal guardian; or

- the subject of a Qualified Medical Child Support Order that is not inconsistent with this definition.

Eligible Employee - a person who is classified by the Employer on both payroll and personnel records as a full-time employee of the Employer and who is regularly scheduled to work and Actively Working at least the minimum number of hours required by the Employer to be full-time. The term Eligible Employee does not include employees who work on a part-time, temporary, or substitute basis, leased employees, or individuals classified by the Employer as an independent contractor or in an ineligible class (regardless of how classified by a court or an administrative agency).

Eligible Retiree – an eligible Employee who is covered under this Plan and who retires under the Employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution and satisfies any other eligibility and enrollment requirements imposed by the Employer.

Identification Card (ID Card) - a card given to a Member to show he/she is enrolled in the Plan.

Injury - an accident that causes bodily harm.

Maximum Allowable Payment (MAP) - the highest amount that will be paid for Covered Dental Services under the Plan, as limited by the Dental Services reimbursement schedule established by the Plan.

Maximum Benefit Amount - the maximum dental benefit that will be payable under the Plan during a Plan Year. The Maximum Benefit Amount is shown in the Schedule of Benefits.

Medically Necessary or Medical Necessity – the services must be necessary and customary under generally accepted dental practices, and deemed by the profession to be appropriate.

Medicare - a federal government program that provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities.

Member - a person who has met all of the eligibility requirements and is properly enrolled in the Plan.

Plan Sponsor – County of Moore, or any successor thereto.

Plan Year - the 12-month period beginning on July 1 of each year.

Provider - a person or place licensed to provide the type of dental services that may qualify as Covered Dental Services.

ELIGIBILITY AND ENROLLMENT

Employee Enrollment

Only an Eligible Employee can enroll in the Plan. If a husband and wife are both Eligible Employees, only one may enroll his or her Eligible Dependents in the Plan. The Plan Administrator, in its sole discretion, will determine whether an individual may enroll in the Plan as an Eligible Employee or an Eligible Dependent.

If you are not classified as an Eligible Employee, but you are later reclassified as such either by the Plan Administrator or a governmental or judicial authority, you will be eligible to participate in the Plan only prospectively (assuming all other eligibility requirements are met). You will not be eligible to participate in the Plan retroactively for the period of time you were excluded from the Plan because of such classification.

An Eligible Employee must enroll within 30 days of his or her Eligibility Date. If an Eligible Employee completes the enrollment process required by the Plan Administrator within 30 days of the date of hire, the Eligible Employee's coverage will be effective on the date of hire. In all other cases, coverage will be effective on the date designated by the Plan Administrator following enrollment. If the Eligible Employee does not complete the required enrollment process within the required time period, he or she will not be permitted to enroll in the Plan until the following Annual Enrollment Period (unless the Eligible Employee experiences a Qualifying Change in Status, discussed below).

ID Cards will be issued to you with the date each individual's coverage is effective and other important information about benefits. To make sure you receive all communications, please notify the Plan Administrator or FCC when there is an address or name change.

Retiree Enrollment

An Eligible Retiree may elect to continue to participate in the Plan when coverage would otherwise terminate on account of his or her retirement. If elected, this coverage will be in lieu of COBRA Continuation Coverage. Eligible Retirees who do not elect to continue their coverage when first eligible will not be given another chance to do so. In addition, if an Eligible Retiree drops coverage during an Annual Enrollment Period, he or she will not be permitted to re-enroll in the Plan at a later date.

Eligible Retirees are not entitled to enroll their Eligible Dependents. This means that an Eligible Dependent will have to elect COBRA Continuation Coverage in order to continue to participate in the Plan after coverage is lost on account of an Eligible Retiree's retirement.

Dependent Enrollment

Only Eligible Dependents may be enrolled by the Eligible Employee. Proof of Eligible Dependent status may be required from time-to-time. If proof is not provided when requested, the dependent may not be enrolled or may be disenrolled.

If an Eligible Dependent is enrolled when the Eligible Employee enrolls, the Eligible Dependent's coverage will be effective at the same time as the Eligible Employee's coverage.

Qualified Medical Child Support Orders

Generally, qualified medical child support orders ("QMCSOs") are legal orders requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order that is issued by an appropriate court or administrative agency, which contains certain information. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. The QMCSO may not require a plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the plan. It is the responsibility of the Plan Administrator to determine if a child is eligible under a QMCSO. A copy of the Plan's procedures governing QMCSOs may be obtained, without charge, by contacting the Plan Administrator.

Mid-Year Enrollment (and Disenrollment)

Eligible Employees and their Eligible Dependents may enroll (or disenroll) at certain times other than during the Annual Enrollment Period.

If an Eligible Employee experiences a Qualifying Change in Status and would like to change his or her election for coverage, the Eligible Employee must notify the Plan Administrator and make a new election within 30 days of the event. The election change will be effective prospectively on the date specified by the Plan Administrator.

A Qualifying Change in Status is defined as one of the following events relating to the Eligible Employee:

- Marriage;
- Divorce, annulment or legal separation;
- Birth, adoption or placement for adoption of an Eligible Dependent;
- Gain or loss by an Eligible Dependent of eligibility status;
- Death of an Eligible Dependent;
- Change in an Eligible Dependent's place of employment;
- Change in the Eligible Employee's or an Eligible Dependent's employment from full-time to part-time or vice versa (provided the change affects the individual's eligibility for coverage);
- Taking or returning from an unpaid leave of absence by the Eligible Employee or an Eligible Dependent;
- An Eligible Dependent's loss or gain of coverage through his or her employer's dental plan;
- A QMCSO requiring coverage under the Plan;
- Entitlement to or loss of Medicare or Medicaid;
- A significant cost or coverage change; or
- A change in coverage under another employer plan for a period of coverage that is different from the period of coverage under the Plan, such as during an open enrollment period.

In some cases, to be allowed, the event must affect eligibility for coverage under the Plan and the election change must be consistent (under IRS rules) with the event that has occurred. In all cases, the election change must be permitted under IRS rules, if applicable.

When Enrollment Ends

Enrollment of the Eligible Employee and all Eligible Dependents ends on the earliest of the following dates –

- The date on which the Plan is terminated.
- The last day of the pay period in which the Eligible Employee terminates employment (or otherwise fails to satisfy the applicable eligibility requirements) or such later date designated by the Employer unless the Eligible Employee is also an Eligible Retiree and he or she elects to continue to participate in the Plan as an Eligible Retiree in which case coverage will continue for the Eligible Retiree but not his or her Eligible Dependents.
- The last day of a period for which contributions for the cost of coverage have been made if the contributions for the next period are not made when due.
- The last day of the pay period in which the Eligible Employee revokes his or her election for coverage (which generally must be made prospectively) provided such revocation is otherwise permitted under the terms of the Plan.
- With respect to an Eligible Dependent, the last day of the pay period in which he or she fails to satisfy the applicable eligibility requirements provided that in no event will coverage for an Eligible Dependent Child end before the last day of the month in which the child turns age 26.
- With respect to an Eligible Dependent, the date the Plan is amended to end dependent coverage or such later date designated by the Employer.
- With respect to an Eligible Dependent, the last day of the pay period in which he or she becomes covered as an Eligible Employee under the Plan.

In certain cases when enrollment ends, Members may elect COBRA Continuation Coverage. See the "COBRA Continuation Coverage" section of this booklet for additional information.

Enrollment of an Eligible Retiree ends on the earliest of the following dates –

- The date on which the Plan is terminated.
- The last day of a period for which contributions for the cost of coverage have been made if the contributions for the next period are not made when due.
- The last day of a period for which contributions for the cost of coverage have been made if the Eligible Retiree revokes his or her election for coverage under the Plan.

- For Eligible Retirees who are hired on or after January 1, 2010, the date the Eligible Retiree becomes eligible for Medicare at age 65.

The Plan Administrator also may disenroll a Member with written notice to the Member if the Member engages in any of the following:

- Knowingly provides false or incomplete information with fraudulent intent;
- Engages in conduct that interferes with providing Covered Dental Services; or
- Permits the use of the ID Card by another person.

The Member will be responsible for any costs incurred due to the above conduct.

Except where COBRA Continuation Coverage is elected, the Plan shall not have any responsibility for payment for any Dental Services provided after the date of disenrollment regardless of the reason for disenrollment.

SCHEDULE OF BENEFITS

Plan Year Deductible

Class A Services (Preventive)

No Deductible

Class B Services (Basic) and Class C Services (Major) Combined

$50 Individual and $100 Family

Benefit Payable per Plan Year

Class A Services – Preventive	90% of Maximum Allowable Payment - no Deductible
Class B Services – Basic	60% of Maximum Allowable Payment after Deductible
Class C Services – Major	50% of Maximum Allowable Payment after Deductible

Maximum Benefit Amount

For Class A, B, and C services combined:

Per Member per Plan Year	$1,000

COVERED DENTAL SERVICES

Each Plan Year, benefits will be paid to a Member for Covered Dental Services in excess of the Deductible if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

Class A Services: Preventive And Diagnostic Dental Procedures

The limits on Class A services are for routine services. If a dental need is present, the Plan will consider providing coverage for Dental Services more frequently than the limits shown below.

- Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two per Member each Plan Year.
- One bitewing x-ray series. Limited to two per Member each Plan Year.
- One full mouth x-ray. Limit one per Member every three Plan Years.
- Two fluoride treatments for enrolled dependent children under age 19 each Plan Year.
- Space maintainers for enrolled dependent children under age 19 to replace primary teeth.
- Emergency palliative treatment for pain.
- Sealants on the first and second molars for dependent children from age 5 to 15. One reapplication per tooth is covered.

Class B Services: Basic Dental Procedures

- Dental x-rays not included in Class A.
- Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- Periodontics (gum treatments).
- Endodontics (root canals).
- Extractions. This service includes local anesthesia and routine post-operative care.
- Recementing bridges, crowns or inlays.
- Fillings, other than gold.
- General anesthetics (including nitrous oxide) upon demonstration of Medical Necessity.
- Antibiotic drugs.

Class C Services: Major Dental Procedures

- Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

- Installation and repair of crowns.

- Installing precision attachments for removable dentures.

- Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during the 6 month period following the installation.

- Addition of clasp or rest to existing partial removable dentures.

- Initial installation of bridgework and removable dentures.

- Repair of bridgework and removable dentures.

- Rebasing or relining of removable dentures.

- Implants and/or orthodontia for the treatment of one or more congenitally missing teeth.

- Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met.

    - The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

    - The existing denture is temporary. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

EXCLUSIONS AND LIMITATIONS

The following services, items, and supplies are not Covered Dental Services under the Plan:

- Administrative costs of completing claim forms or reports or for providing dental records.

- Charges for missed dental appointments.

- Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

- Oral hygiene, plaque control programs or dietary instructions.

- Implants, including any appliances and/or crowns and the surgical insertion or removal of implants, except for the treatment of a congenitally missing tooth.
- Services which are not included in the lists of Covered Dental Services.
- Orthognathic surgery.
- Orthodontic Treatment, except for the treatment of a congenitally missing tooth.
- Personalization of dentures.
- Replacement of lost or stolen appliances.
- Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- Cosmetic Services.
- The cost of Covered Dental Services that exceed the Maximum Allowable Payment.
- Covered Dental Services which are not Medically Necessary.
- Covered Dental Services which are attributable to an illness or injury sustained by the Member in connection with the Member's active military duty.
- Any Covered Dental Service to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically include, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments and homeowner's insurance.
- Charges incurred for Dental Services which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or charges that would not have been made if no coverage existed or charges that a Member is not required to pay.
- Charges incurred for Dental Services which arise out of or in the course of any employment for wage or profit, including self-employment, with respect to which the Member was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

HOW TO CLAIM BENEFITS FOR COVERED DENTAL SERVICES

In most cases, Providers will submit Claims to FCC on the Member's behalf. Some Providers may require payment at the time of service and the Member may be responsible for filing the Claim. In that circumstance, payment will be issued to the Member rather than to the Provider. When submitting a Claim, Members must submit copies of bills for all charges. Claim forms may be obtained from the Plan

Administrator or FCC using the contact information provided later in this document. Claim forms are also available online at www.firstcarolinacare.com

The Member or the Provider must mail the Claim to FCC within 180 days after the date of service. Services for which a Claim is not received within 180 days after the date of service will not be a Covered Dental Service unless it was not reasonably possible for the Claim to be filed within the 180 day period. In such case, the Claim must be filed as soon as reasonably possible but in no case later than one (1) year from the time submittal of the Claim is otherwise required, except in the absence of legal capacity of the Member.

PLEASE MAIL COMPLETED CLAIMS TO:
FirstCarolinaCare Insurance Company
PO Box 381686
Birmingham, AL 35238

Notice Procedures for Claims

If a Member or the Member's Provider files a Claim, the Member will receive written notice of the determination, also known as an "Explanation of Benefits", within 30 days of the date FCC receives the Claim. If additional information is needed to process the Claim, FCC will notify the Member. If FCC requests additional information and does not receive the information within 45 days of the request, the Claim will be denied and a notice sent to the Member.

If a Member believes that a claim was not paid correctly by FCC, the Member should call Member Services (see "Important Telephone Numbers"). If the issue cannot resolved to the Member's satisfaction by Member Services, the Member may appeal the decision by following the procedures described later in this booklet.

COORDINATION OF BENEFITS

Order of Payment

If a Member is enrolled in another group dental plan, benefits may be coordinated with the other plan so that benefits paid by both plans do not exceed the maximum allowable for the Covered Dental Service. When benefits are coordinated, one plan pays first ("primary plan") and the other plan's ("secondary plan") benefits may be reduced accordingly. The rules regarding order of payment are briefly described as follows:

- The plan covering a person as an employee is primary.
- The plan covering a person as a spouse is secondary.
- The plan covering a child as a dependent of the parent whose birth date falls first during the year is primary.
- If both parents have the same birth date, the plan that has covered a parent for the longer period of time will be primary.

- If the parents are divorced or separated, the plan that covers the child as a dependent of the parent with custody is primary.

    - The plan that covers the child as a dependent of the spouse of the parent with custody is primary to -

    - The plan that covers the child as a dependent of the parent without custody.

- If there is a court order that requires a parent to purchase the child's dental coverage and FCC has knowledge of the court order, then that plan will be primary.

- A plan that covers a person other than as a laid-off or retired employee or as a dependent of other than a laid-off or retired employee is primary to a plan that covers the person as a laid-off or retired employee (unless this results in a conflict in determining order of benefits).

- If none of the above rules apply, the plan that has covered a person the longest is primary.

- If the other plan does not have rules that establish the same order of benefits as this Plan, then that plan will be primary.

In order to determine whether coordination of benefits applies, FCC may request information from the Member. A prompt reply will help FCC process the Claim more quickly.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this Plan. If it does, FCC may pay the amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid under this Plan and this Plan will not have to pay that amount again.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under the coordination of benefits rules, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their eligible family members the opportunity to continue such coverage at group rates in certain circumstances when coverage would otherwise be lost. (For COBRA purposes, a loss of coverage includes an increase in the cost of such coverage.) FCC is the COBRA Administrator. The contact information for the COBRA Administrator is:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Phone: 910.715.8100
Fax: 910.715.8101

COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise be lost because of a life event known as a "qualifying event." Specific qualifying events are identified below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage will be required to pay for COBRA continuation coverage.

Eligibility and Coverage

You will become a qualified beneficiary if you lose your coverage under the Plan (or the cost of coverage under the Plan increases) because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your covered spouse will become a qualified beneficiary if he or she loses coverage under the Plan (or the cost of coverage under the Plan increases) because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- You and your spouse divorce.

Also, if you reduce or eliminate your spouse's coverage under the Plan in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for your spouse even though his or her coverage was reduced or eliminated before the divorce.

Your Eligible Dependent children will become qualified beneficiaries if they lose coverage under the Plan (or the cost of coverage under the Plan increases) because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;

- Your employment ends for any reason other than your gross misconduct;
- You and your spouse divorce; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Children born to or placed for adoption with you during the continuation coverage period may also elect continuation coverage, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

If the Employer files bankruptcy and it causes an Eligible Retiree who is enrolled in the Plan to lose coverage, it may be a qualifying event for the Eligible Retiree. In that situation, if COBRA continuation coverage is elected, it will continue until the Eligible Retiree's death unless any of the events described below that would cause the coverage to terminate early occur.

Required Notice of Qualifying Events

Under the law, you or a covered Eligible Dependent (or a representative) has the responsibility to inform the COBRA Administrator of a divorce or a child's loss of dependent status under the Plan. To be eligible for continued coverage, the COBRA Administrator must be informed of the event within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of an Eligible Dependent child after the qualifying event, you must notify the COBRA Administrator of the birth or adoption of the child whom you wish to enroll under the Plan. The notice procedures are described below. (The Employer must notify the COBRA Administrator of your death, termination of employment or reduction in work hours.) If this notice is not timely and properly provided, the Qualified Beneficiary will not be permitted to elect COBRA continuation coverage.

COBRA Election Period

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered, when appropriate, to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the Plan or the date of notification to elect continuation coverage.

To elect COBRA continuation coverage, you or the qualified beneficiary (or a representative) must complete the election form that has been mailed to you (or the qualified beneficiary) and submit it to the COBRA Administrator by mail at the address specified above or by faxing it to the fax number listed above. If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the qualifying event. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications, including in-person or telephonic statements about an individual's COBRA coverage, and electronic communications (other than faxed communications), including e-mail.

You may elect COBRA continuation coverage on behalf of your eligible spouse, and you or your spouse may elect COBRA continuation coverage on behalf of your eligible children. If you or your eligible spouse elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event.

Description and Maximum Length of COBRA Coverage

If continuation coverage is elected, the qualified beneficiary will receive coverage identical to that provided under the Plan for similarly situated employees or family members. If the Employer changes the benefits which are offered under the Plan during the COBRA continuation period, COBRA continuation coverage will also be changed in the same manner.

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the qualifying event. These time periods are described in general below.

36-Month Period

When the qualifying event causing loss of coverage is your death, your divorce, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

18-Month Period

When the qualifying event causing loss of coverage is the end of your employment or reduction in your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA continuation coverage for other qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If a qualified beneficiary who has elected COBRA continuation coverage becomes entitled to Medicare or first learns that he or she is entitled to Medicare after submitting an Election Form, the qualified beneficiary must notify the COBRA Administrator of the date of his or her Medicare entitlement at the address specified herein. The notice procedures are described below.

The maximum COBRA coverage period for your newborn or newly-adopted child is measured from your original Qualifying Event. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements. A person who becomes the spouse of a Qualified Beneficiary (including a new spouse of an employee) or dependent child of a Qualified Beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a Qualified Beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Described below are two ways in which the general 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18 month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and the COBRA Administrator is notified in a timely fashion, you and your family members who are receiving COBRA coverage may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The Social Security

Administration must determine that the disability started at some time before the 60th day of COBRA continuation coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In order to qualify for the extension, you or the disabled qualified beneficiary (or a representative) must notify the COBRA Administrator in writing of the Social Security Administration's determination before the end of the 18-month period of COBRA continuation coverage and within 60 days after the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the qualified beneficiary would lose coverage under the Plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described below.

Second qualifying event extension of 18 month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months (or 29 months in case of a disability extension) of COBRA continuation coverage, your spouse and dependent children in your family can get additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die or divorce, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose such coverage under the Plan had the first qualifying event not occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For cases of second qualifying events, the qualified beneficiary must notify the COBRA Administrator in writing within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would have lost coverage under the Plan due to the second qualifying event if it had occurred before the first qualifying event. The procedures for providing this notice are described below.
Failure to provide timely and properly provide notice of a disability determination or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if any one of the following events occurs:

- The Qualified Beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals).
- The Qualified Beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the Social Security Administration makes a final determination that the Qualified Beneficiary is no longer disabled.
- All group health plans for all of the Employer’s active employees are terminated.

If, during the period of COBRA coverage, a qualified beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the qualified beneficiary (or a representative) must notify the COBRA Administrator in writing within 30 days of the later of: (1) the date the other coverage becomes effective, or (2) the exhaustion or satisfaction of any preexisting condition exclusions affecting the qualified beneficiary. If, during the period of COBRA coverage, a qualified beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, you or the qualified beneficiary (or a representative of either) must notify the COBRA Administrator in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card). The procedures for providing this notice in both of these circumstances are described below.

If the Social Security Administration determines that a qualified beneficiary is no longer disabled, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the determination. The qualified beneficiary must notify the COBRA Administrator in writing within 30 days after the Social Security Administration's determination that he or she is no longer disabled. The procedures for providing this notice are described below.

If notice of these events is not timely and properly provided, the Qualified Beneficiary's COBRA coverage may be terminated retroactively and the qualified beneficiary may be required to repay a portion of the benefits received.

A qualified beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA coverage is provided subject to the qualified beneficiary's eligibility for coverage. The COBRA Administrator reserves the right to terminate a qualified beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible.

Premium Payments

A qualified beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

Qualified beneficiaries will be notified of the cost of continuing benefits if he or she experiences a qualifying event. The qualified beneficiary will have 45 days from the election date to pay the first premium; after that, premiums will be due and payable on the first day of the month. The first premium should cover the premium due from the date coverage is lost through the date COBRA is elected, plus any monthly premium that becomes due during the 45 day payment period. There will be a 30 day grace period to pay each subsequent monthly premium.

If the initial premium payment is not made by the end of the 45 day payment period, the qualified beneficiary will lose all COBRA rights and coverage will not take effect. If a subsequent monthly premium payment is not received by the first day of the coverage period to which it applies (e.g., the first day of the month), COBRA coverage will be suspended as of that day and then retroactively reinstated if the monthly payment is received prior to the end of the 30 day grace period. If the premium is not paid prior to the end of the grace period, the qualified beneficiary will lose all COBRA rights. The first payment and all monthly payments must be mailed to the COBRA Administrator at the address above.

The required monthly premiums may also change during the COBRA continuation period in the manner allowed by law. Qualified beneficiaries will be notified of any changes in benefits and/or rates during the applicable COBRA continuation period.

Notice Procedures

As a condition of receiving COBRA coverage, you or your covered Eligible Dependent (or a representative) must notify the COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial qualifying events
- Second qualifying events
- A qualified beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Each of these events, including the time period for providing notice of the event, has been discussed previously. Notice of these events must be given in writing and must be mailed to the COBRA Administrator at the address listed above. The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each qualified beneficiary experiencing the COBRA-related event, the name of the Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled. The notice must be postmarked no later than the applicable deadline for giving the notice.

Additional documentation supporting the notice may be required. If such information is requested and it is not provided within 15 business days of the request, the notice will not be considered timely and continuation coverage may not be available.

If the notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all qualified beneficiaries who are required to give the notice.

If you have questions about your right to coverage, contact the COBRA Administrator.

Keep the Plan Informed

In order to protect your rights, you should keep the Employer and the COBRA Administrator informed of any changes in the addresses of your family members. If you have changed your marital status, or you or your spouse have changed addresses, it is your responsibility to notify the COBRA Administrator. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

USERRA CONTINUATION COVERAGE

If you or your Eligible Dependents lose coverage under the Plan as a result of your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any Eligible Dependents. Your Eligible Dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your Eligible Dependents, your Eligible Dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered Dependents) under USERRA, you must pay 102% of the full premium elected (the same rate as COBRA) at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active employee.

USERRA continuation coverage will continue for 24 months following the date your leave of absence begins. However, your coverage will terminate earlier if any of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

CLAIMS AND APPEALS PROCEDURES

A Member has a right to file a claim for benefits under the Plan, ask if he or she has a right to any benefits under the Plan, or appeal the denial of a claim for benefits under the Plan. For purposes of the Plan's claims procedure, the term "you" shall include any individual making a claim, inquiry or appeal and the authorized representative of such person. You must follow the Plan's procedures for appointing an authorized representative. You should contact the Plan Administrator for additional information regarding these procedures.

All claims and appeals should be in writing and provide all details about the claim or appeal, including the date of the event, place and people involved. Mail to:

CLAIMS:
FirstCarolinaCare Insurance Company
PO Box 381686
Birmingham, AL 35238

APPEALS:
FirstCarolinaCare Insurance Company
Attention: Appeals Coordinator
42 Memorial Drive
Pinehurst, NC 28734

If you file a claim, you will receive written notice of the determination within 30 days of the date FCC receives the claim. If additional information is needed to process the claim, FCC will notify you. You then have 45 days to provide the requested information (or such other period specified by FCC in writing). If, for reasons beyond the control of FCC, an extension of time is required to process the claim, you will receive written notice of the extension, an explanation of the circumstances requiring the extension and the expected date of the decision prior to the end of the 30-day period. In no event will the extension exceed a period of an additional 15 days from the end of the initial 30-day period.

If your claim is denied, in whole or in part, you will receive a written explanation of the denial that will include all information required under applicable law. This includes the specific reason or reasons for the denial, specific reference to the plan provision on which the denial is based, a description of additional information necessary to perfect the claim and a description of the Plan's claims review procedures and

the time limits applicable to such procedures. If applicable, it will also include a statement of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the claim determination (or a statement that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request). In addition, if the claim determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the termination, applying the terms of the Plan to the person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You may request that your claim (or any other adverse benefit determination) be reviewed by FCC. To appeal the denial of a claim (or other adverse benefit determination), you must notify FCC within 180 days of the date of the denial. In connection with an appeal, you have the right to review pertinent documents, records, and other information relevant to your claim and to submit written comments, documents, records, and other information relevant to the appeal of your claim for benefits. Copies of all information relevant to your claim will be provided free of charge upon request.

Your claim will be given a full and fair review. To the extent required by law, the decision on review will not give deference to the initial adverse claim determination and will be conducted by an individual who is not the same individual who made the initial adverse claim determination or a subordinate of such individual. If the claim determination is based in whole or in part on a medical judgment, including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, FCC will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be an individual who is neither an individual who was consulted in connection with the initial claim determination nor a subordinate of any such individual.

If you file an appeal of a claim denial, the decision regarding the appeal will be made by FCC promptly, but not later than 60 days after receipt of your appeal. When the appeal is decided, you will be notified in writing of the results of the review. This notice will include all information required under applicable law. This includes the specific reason or reasons for the denial; specific references to the Plan provision on which the denial is based; a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and a description of the Plan's voluntary appeal procedures. If applicable, it will also include a statement of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the claim determination (or a statement that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request). In addition, if the claim determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the termination, applying the terms of the Plan to the person's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also identify any medical or vocational experts whose advice was obtained in connection with any adverse claim determination.

Exhaustion of Administrative Remedies

Before filing any claim or action in court or in another tribunal with respect to the Plan, you must first fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an initial claim and then seeking a timely appeal of any denial.

Discretionary Authority

With respect to those matters that the Plan Administrator and FCC have been authorized to handle, each such entity has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for dental benefits and to determine the amount of such benefits, and each entity's decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). Benefits under the Plan will be paid only if the Plan Administrator or FCC, as applicable, decides in its discretion that you are entitled to them.

GENERAL PROVISIONS

Plan Name and Sponsor

The name of the plan is the County of Moore Dental Plan. The Plan is sponsored by the County of Moore. The address and telephone number of the County of Moore are:

County of Moore
Courthouse Circle
P. O. Box 905
Carthage, NC 28327
Phone: 1.910.947.6362

Employer Identification Number: 56-6000322

Plan Year

The plan year of the Plan is the twelve-month period beginning July 1 and ending on the following June 30.

Plan Administrator

The Employer is the Plan Administrator of the Plan. One or more individuals may be appointed by the Plan Administer to act on its behalf and at its convenience and/or to use the title "Plan Administrator." The Plan Administrator may adopt rules and procedures as to how the Plan operates and has authority to exercise discretion in performing its duties.

The Plan Administrator's business address and business telephone number are the same as that of the Employer. The Plan Administrator retains all fiduciary responsibilities with respect to the Plan except to the extent that the Plan Administrator has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan. The Plan Administrator shall be the designated agent for the service of legal process.

Type of Plan and Plan Administration

The Plan is a welfare benefit plan that provides self-funded dental benefits to Eligible Employees who have enrolled in the Plan and, in certain cases, their Eligible Dependents. The Plan Administrator is responsible for administering the Plan. The Plan Administrator may retain one or more third parties to provide certain administrative services with respect to administration of the Plan.

Welfare Plan Funding and Source of Contributions

The Employer and the participants share the cost of benefits provided under the Plan. This cost is based on the claims paid under the Plan, plus administrative expenses. The self-funded benefits are funded by the Employer out of its general assets. The Employer has hired FCC to perform certain administrative services with respect to the Plan, including processing claims for benefits. However, the Employer remains responsible for the payment of claims.

Amendment and Termination of Plan

The Employer expects to continue the Plan indefinitely, but it (or its delegate) reserves the right to amend or terminate the Plan, or any of the benefits provided under the Plan, at any time, in whole or in part. The cost of the benefits, including the amount paid by employees, may also be changed from time to time.