COUNTY OF MOORE

CARTHAGE NC

Health Benefit Summary Plan Description

Effective

07-01-2020

BENEFITS ADMINISTERED BY

FirstCarolinaCare
INSURANCE COMPANY

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INTRODUCTION

Effective: 07-01-2020

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. As a valued employee of COUNTY OF MOORE, we are pleased to provide You with benefits that can help meet Your health care needs.

COUNTY OF MOORE is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrator for this Plan is FirstCarolinaCare Insurance Company (hereinafter "FCC"). The Third-Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

COUNTY OF MOORE assumes the sole responsibility for funding the Plan benefits out of general assets, however employees help cover some of the costs of covered benefits through contributions, Deductibles, Co-pays and Coinsurance as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with a capital letter, even though it normally would not be capitalized. These terms have special meaning under the Plan and most capitalized terms will be listed in the Glossary of Terms. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group health Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources department if You have questions.

If You haven't already received this, You will be getting an identification card that You should present to Your health care provider when You receive services. This card also has phone numbers on the back of the card, so You know who to call if You have questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description.

This document becomes effective on July 1, 2020.

Health Insurance Marketplace

Most U.S. citizens are able to purchase health coverage for themselves and their family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." County of Moore believes that the coverage provided by this Plan is affordable and does provide minimum value. You will be given a notice at certain times which explains the coverage offered through Marketplace and any tax credit that may be available to you. You should review that notice carefully. You may request a copy of this notice from the Plan Administrator at any time, and one will be provided free of charge.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (referred to as an "SBC" or "Summary") for the Plan is available. The Summary is based on a short model document required by the Affordable Care Act. The Affordable Care Act requirement is intended to standardize the description of medical options in the United States so that individuals can easily compare medical option choices. While the Summary is a concise "snapshot" of the medical benefits under this Plan, the Summary is not intended to take the place of this Summary Plan Description (SPD) or the official plan document. Nothing in a Summary makes you eligible for this Plan unless the official plan document and this SPD provide for such eligibility or benefits. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

PLAN INFORMATION

Plan Name	COUNTY OF MOORE Group Benefit Plan
Name and Address Of Employer	COUNTY OF MOORE COURTHOUSE CIR PO BOX 905 CARTHAGE NC 28327
Name, Address and Phone Number Of Plan Administrator	COUNTY OF MOORE COURTHOUSE CIR PO BOX 905 CARTHAGE NC 28327 910-947-6362
Named Fiduciary	COUNTY OF MOORE
Employer Identification Number Assigned by The IRS	56-6000322
Type of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the employer's health benefits plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. FCC provides administrative services such as claim payments for medical and pharmacy claims.
Name and Address Of Agent For Service Of Legal Process	COUNTY OF MOORE COURTHOUSE CIR PO BOX 905 CARTHAGE NC 28327
Funding of The Plan	The Plan is a self-funded plan. Benefits are paid from participant contributions and from Moore County's general assets, as needed.
Plan Year	Benefits begin on July 1 and end on the following June 30. For new Employees and Dependents, a Plan Year begins on the individual's Effective Date and runs through June 30 of the same Plan Year.
Compliance	It is intended that this Plan meet all applicable law requirements. In the event of any conflict between this Plan and applicable law, the provisions of applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

Fiduciary Liability

To the extent permitted by law, the Plan Administrator and other parties assuming a Fiduciary role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

BENEFIT CLASS DESCRIPTION

The Covered Person's benefit class is determined by the designations shown below:

Class	Class Description
A01	ALL ACTIVE EMPLOYEES-ADMINISTRATION, GOVERNING BODY AND PERSONAL
A02	ALL ACTIVE EMPLOYEES-FINANCIAL SERVICES
A03	ALL ACTIVE EMPLOYEES-COUNTY ATTORNEYS OFFICE
A04	ALL ACTIVE EMPLOYEES-TAX ADMINISTRATION
A05	ALL ACTIVE EMPLOYEES-ELECTIONS
A06	ALL ACTIVE EMPLOYEES-REGISTER OF DEEDS
A07	ALL ACTIVE EMPLOYEES-SHERIFF OPERATIONS
A08	ALL ACTIVE EMPLOYEES-SHERIFF OPERATIONS-JAIL
A09	ALL ACTIVE EMPLOYEES-CHILD SUPPORT AND DAY REPORTING CENTER
A10	ALL ACTIVE EMPLOYEES-EMERGENCY MEDICAL SERVICES
A11	ALL ACTIVE EMPLOYEES-PUBLIC SAFETY
A12	ALL ACTIVE EMPLOYEES-PLANNING
A13	ALL ACTIVE EMPLOYEES-DEPARTMENT OF CONVENTION VISITORS BUREAU
A14	ALL ACTIVE EMPLOYEES-SOIL AND WATER CONSERVATION
A15	ALL ACTIVE EMPLOYEES-VETERAN SERVICES
A16	ALL ACTIVE EMPLOYEES-AGING ADMINISTRATION
A17	ALL ACTIVE EMPLOYEES-LIBRARY
A18	ALL ACTIVE EMPLOYEES-PARKS AND RECREATION
A19	ALL ACTIVE EMPLOYEES-SOCIAL SERVICES
A20	ALL ACTIVE EMPLOYEES-HEALTH DEPARTMENT

Class	Class Description
A21	ALL ACTIVE EMPLOYEES-PUBLIC WORKS-WASTE DISPOSAL
A22	ALL ACTIVE EMPLOYEES-PUBLIC WORKS-WASTE WATER
A23	ALL ACTIVE EMPLOYEES-PUBLIC WORKS-UTILITIES
A24	ALL ACTIVE EMPLOYEES-PROPERTY MANAGEMENT
A25	ALL ACTIVE EMPLOYEES-AIRPORT
A26	ALL ACTIVE EMPLOYEES-INFORMATION TECHNOLOGY
A27	ALL ACTIVE EMPLOYEES-MCTS OPERATIONS
A28	ALL ACTIVE EMPLOYEES-PINEHURST AREA CONVENTION VISITORS BUREAU
A29	ALL ACTIVE EMPLOYEES-DISTRICT ATTORNEY OFFICE
A30	ALL ACTIVE EMPLOYEES-GIS
C01	ALL COBRA PARTICIPANTS
R01	ALL RETIRED EMPLOYEES

LOCATION DESCRIPTION

Location	Description
001	COUNTY OF MOORE COURTHOUSE CIR PO BOX 905 CARTHAGE NC 28327

IMPORTANT FCC TELEPHONE NUMBERS

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

Pharmacy Benefits Manager
For questions related to Prescription Drug benefits, call MedImpact Healthcare Systems, Inc. ("MedImpact") at: **800-788-2949 (toll-free)**

Prior Authorization - Medical
To request Prior Authorization or for questions related to Prior Authorization of medical procedures, call Member Services at: **800-574-8556 (toll-free)**

Prior Authorization – Prescription Drugs
To request Prior Authorization or for questions related to Prior Authorization for prescription drugs, call MedImpact at: **800-788-2949 (toll-free)**

Nurse Helpline
To receive confidential personal health information or general health information on various health related topics, call: **800-336-2121 (toll-free)**

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

SCHEDULE OF BENEFITS

Benefit Plan

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime, individual and family Deductibles, Co-pays, Coinsurance, and Out-of-Pocket Maximums, and are subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

NOTE: Certain covered benefits require prior authorization before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this document for a description of these services and prior authorization procedures.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Medical Annual Deductible Per Plan Year:		
☐ Per Person	$1,500	$3,000
☐ Per Family	$3,000	$6,000
Coinsurance, Unless Otherwise Stated Below:		
☐ Paid By Member After Satisfaction Of Deductible	30%	40%
Medical Annual Out-Of-Pocket Maximum:		
☐ Per Person	$5,000	$9,000
☐ Per Family	$10,000	$18,000
Ambulance And Other Medically Necessary Emergency Transportation:		
☐ Paid By Member After Deductible	30%	30%
Chiropractic Services:		
Office Visit:		
☐ Paid By Member	30% (Deductible Waived)	40% (Deductible Waived)
Manipulations:		
☐ Paid By Member	30% (Deductible Waived)	40% (Deductible Waived)
X-rays:		
☐ Paid By Member	30% (Deductible Waived)	40% (Deductible Waived)
Durable Medical Equipment:		
☐ Paid By Member After Deductible	30%	40%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Sub-acute Facility:		
Maximum Days Per Plan Year	30	
☐ Paid By Member After Deductible	30%	40%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Benefits:		
☐ Maximum Visits Per Plan Year	100	
☐ Paid By Member After Deductible	30%	40%
Hospice Care Benefits:		
☐ Paid By Member After Deductible	30%	40%
Hospital Services Including Physician Services While In The Hospital:		
Inpatient - Room And Board Subject To The Payment Of Semi-private Room Rate:		
☐ Paid By Member After Deductible	30%	40%
Emergency:		
☐ Copay Per Visit	$250	
(Waived If Admitted Within 24 Hours)		
☐ Paid By Member After Deductible		
☐ Paid By Member After Deductible	30%	30%
Urgent Care:		
☐ Paid By Member After Deductible	30%	30%
Outpatient Charges:		
☐ Paid By Member After Deductible	30%	40%
Mental Health and Substance Abuse Disorder Benefits:		
Inpatient Services / Physician Charges:		
☐ Paid By Member After Deductible	30%	40%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
☐ Paid By Member After Deductible	30%	40%
Office Visit:		
☐ Co-pay Per Visit	$35	Not Applicable
☐ Paid By Member After Deductible	0% (Deductible Waived)	40%
Physician Office Visit:		
Office Visit: (Including services of a General Practitioner, Family Practice, OBGYN, Internal Medicine, Pediatrics Physician Assistant and Nurse Practitioner)		
☐ Copay Per Visit	$35	Not Applicable
☐ Paid By Member After Deductible	0% (Deductible Waived)	40%
FirstHealth on the Go Telemedicine		
☐ Copay Per Visit		
☐ Paid By Member After Deductible	$10 0% (Deductible Waived)	Not Applicable 40%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
IUD Insertion and Removal In Physician's Office:		
☐ Copay Per Visit	$0	Not Applicable
☐ Paid By Member After Deductible	0% (Deductible Waived)	40%
Maternity Services in Physician's Office		
☐ Copay Per Visit	$0	Not Applicable
☐ Paid By Member After Deductible	0% (Deductible Waived)	40%
Specialist Visit:		
☐ Copay Per Visit	$70	Not Applicable
☐ Paid By Member After Deductible	0% (Deductible Waived)	40%
Surgical Services in Physician's Office:		
☐ Copay Per Visit	$70	Not Applicable
☐ Paid by Member after Deductible	0% (Deductible Waived)	40%
Allergy Injections:		
☐ Paid By Member After Deductible	30%	40%

Benefits are provided for certain covered services and supplies relating to Preventive Care received from an in-network provider, including related x-rays and laboratory tests, with no cost sharing. Coverage is limited each benefit period as described in the Schedule of Benefits. Preventive or Routine Care includes screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Any charges that are diagnostic in nature and outside of the plan's frequency and age limitations will be covered according to the Plan's Deductible, Co-Pays and Coinsurance and subject to medical necessity.

The Plan covers all federally-required preventive services with no cost-sharing. These services are described in the United States Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and Health Resources and Services Administration (HRSA) Guidelines. A comprehensive listing of all the required preventive care items and services may be found at http://www.healthcare.gov/coverage/preventive-care-benefits/. The Plan is not required to provide coverage for new recommendations from the USPSTF until the first plan year that begins one year or later after the recommendation or guideline is issued. For those recommendations that apply specifically to high risk groups, the individual's attending physician will determine whether the individual is in the high-risk group. Additional information regarding women's preventive care is provided later in this SPD.

If a specific preventive care item or service does not specify a limitation on the frequency, method, treatment or setting, the Plan may apply reasonable limitations. Also, the applicable office visit or facility copayment may apply if (a) the preventive service is billed separately from the office visit, or (b) the primary purpose of the office visit is other than the delivery of preventive service and the preventive service is not billed separately from the office visit.

If there is not a network provider who can provide the particular preventive care item or service that is needed, the Plan will cover the item or service when performed by an out-of-network provider at 100% without any cost-sharing.

Covered preventive care services and items include, but are not limited to:

Routine Care Benefits Include:	IN-NETWORK	OUT-OF-NETWORK
Routine Physical Exams At Appropriate Ages:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Immunizations: (Including Flu mist Vaccine and Hepatitis Immunization)		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Routine Diagnostic Tests, Lab & X-rays At Appropriate Ages:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Routine Diagnostic Mammograms:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Pap Test And Pelvic Exams:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
PSA Test & Prostate Exams:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
☐ Paid By Member	0% (Deductible Waived)	No Benefit
Routine Hearing Exam:		
☐ Paid By Member	30% (Deductible Waived)	No Benefit

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Routine Oral Fluoride Supplements (generic drops and tablets) Prescribed For Children Ages 6 Months To 6 Years Whose Primary Water Source Is Deficient In Fluoride: □ Paid By Member	0% (Deductible Waived)	No Benefit
Routine Alcohol And Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition Counseling: ☐ Paid By Member	0% (Deductible Waived)	No Benefit
Shingles Vaccination: Ages 50 And Over ☐ Paid By Member	0% (Deductible Waived)	No Benefit
Second Surgical Opinion: ☐ Paid By Member	0% (Deductible Waived)	100% (Deductible Waived)
Therapy Services: ☐ Paid by Member After Deductible	30%	40%
All Other Covered Expenses: ☐ Paid By Member After Deductible	30%	40%

TRANSPLANT BENEFITS SUMMARY

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Approved Transplant Services:		
☐ Paid By Member After Deductible	30%	40%
Travel and Housing:*		
☐ Maximum Benefit Per Lifetime	$5,000	No Benefit
☐ Paid By Member	0% (Deductible Waived)	
*For up to one year from date of transplant.		
Transplant services must be received at a FACT Accredited Facility		

PRESCRIPTION BENEFIT SUMMARY

Benefit Plan ALL

Member pays $150 individual deductible/$300 family deductible for Preferred Brand Name and Non-Preferred Brand Name drugs before copays apply. There is no deductible for generic drugs. Retail Pharmacy and Mail Order prescriptions are combined to meet deductible.

In-Network Prescription Drug Out-of-Pocket Maximum
Individual $1,500
Family $3,000

By Participating Pharmacy:
☐ Your Co-pay Amount Per Prescription Or Refill For Up To A 30-Day Supply:

Generic:
☐ Co-pay Per Prescription (Tier 1) $10

Preferred Brand Name:
☐ Co-pay Per Prescription (Tier 2) $45

Non-preferred Brand Name:
☐ Co-pay Per Prescription (Tier 3) $60

By Participating Mail Order Pharmacy:
☐ Your Co-pay Amount Per Prescription For Maintenance Products For Up To A 90-Day Supply:

Generic:
☐ Co-pay Per Prescription (Tier 1) $30

Preferred Brand Name:
☐ Co-pay Per Prescription (Tier 2) $135

Non-preferred Brand Name:
☐ Co-pay Per Prescription (Tier 3) $180

Out of Network Prescription Drug Out-of-Pocket Maximum
Individual $3,000
Family $6,000

FirstCarolinaCare Cost-Sharing Assistance Program
FirstCarolinaCare offers patient advocacy services for coordination and identification of prescriptions eligible for cost-sharing assistance.

The Cost-Sharing Assistance Program works like this:

- For eligible drugs, the cost-sharing amount per 30-day prescription will be up to 30% of the total cost.
- Manufacturer assistance programs will cover on your behalf most, if not all, of this coinsurance amount. Regardless of the amount of assistance, you will never be required to pay more for the prescription drug than you would have paid without the Program. This means you will not be penalized for participating in the Program.
- Amounts paid by the manufacturer toward the cost of the drug do not apply toward your annual out-of-pocket maximum or deductible, if applicable, except where required by law.

By Non-Participating Pharmacy: You will need to pay for the prescription up front, then submit a written request to MedImpact Healthcare Systems for reimbursement. You can be reimbursed for covered prescription products up to the contracted rate of a participating pharmacy. Applicable copayments and deductible apply.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles, but they do apply toward satisfaction of the out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise.

Only Covered Expenses will count toward meeting the Deductible. Pharmacy expenses do not count toward meeting the Medical Deductible of this Plan, and medical expenses do not count toward meeting the Prescription Drug Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident and incurred during that Plan year.

COINSURANCE

Coinsurance is a set percentage of the Covered Expense that Covered Persons must pay (generally after the Deductible is satisfied), until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Coinsurance is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, negotiated rate, or Maximum Allowable Payment as applicable. Once the annual out-of- pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum for medical benefits and the annual out-of-pocket maximum for prescription drug benefits are shown on the Schedule of Benefits and Prescription Benefit Summary. Generally, amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays and Coinsurance, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Amounts that a person incurs for medical expenses will not apply to the prescription drug out-of-pocket maximum, and amounts a person incurs for prescription drug expenses will not count towards the medical out-of-pocket maximum.

The medical out-of-pocket maximum takes into account all cost-sharing amounts that you pay under the medical portion of the Plan (e.g., Copayments, Coinsurance and similar charges). The following will not be used to meet the medical out-of-pocket maximum:

- ☐ Penalties, legal fees and interest charged by a provider.
- ☐ Expenses for excluded services.
- ☐ Any charges above the limits specified elsewhere in this SPD.
- ☐ Provider balance-billed amounts.

☐ Expenses above reasonable and customary charges.
☐ Any amount you pay because the prior authorization requirements were not met.

The prescription drug out-of-pocket maximum takes into account all cost-sharing amounts that you pay under the prescription drug portion of the Plan (e.g., Copayments, Coinsurance and similar charges). However, the prescription drug out-of-pocket maximum does not include cost-sharing under the medical portion of the Plan, premiums, charges for non-covered services, balance-billed amounts, the difference between the cost of a brand name prescription and the cost of a generic prescription when a generic prescription is available*, and other special charges and penalties.

* This does not apply to brand name contraceptives which are covered under the Plan if the brand name is medically necessary as determined by your physician. If the Covered Person (through his or her prescriber) follow the exceptions process indicating that a non-preferred Prescribed Contraceptive Drug or Device is Medically Necessary, the Covered Person will have no additional cost-sharing for that non-preferred Prescribed Contraceptive Drug or Device. To begin the exceptions process, the Covered Person should call the number on her ID card.

NOTE: The medical out-of-pocket maximum and the prescription drug out-of-pocket maximum when combined will not be more than the maximum out-of-pocket limit allowed by the Affordable Care Act for in-network coverage for essential health benefits. For 2020, that maximum amount is $7,900 for single coverage and $15,800 for all other dependent tiers. In addition, regardless of the coverage tier (e.g., single or family), no individual will have to pay more than the ACA individual out-of-pocket maximum for in-network benefits (for 2020, $7,900) before the Plan pays covered claims at 100% for that individual for the balance of the plan year.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES
The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Coinsurance) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person’s claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works the minimum number of hours required by the Employer to be full time, or an elected official that agrees to pay Plan premiums at their own expense, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- ☐ Temporary or leased employees.
- ☐ An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- ☐ A consultant who is paid on other than a regular wage or salary by the employer.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

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.

NOTE: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

An **eligible Dependent** includes:

- ☐ Your legal spouse. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. In addition, your legal spouse shall not be eligible if he or she is eligible for coverage through another employer-sponsored health plan which provides minimum essential coverage. Documentation on a Covered Person's eligibility may be required by the Plan Administrator.

- ☐ A Dependent Child that resides in the United States until the Child reaches his or her 26th birthday. A Dependent Child's coverage will not terminate until the last day of the month in which the Child turns age 26. The term "**Child**" includes the following Dependents:

- ☐ A natural biological child;
- ☐ A step child;
- ☐ A legally adopted child or a child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 26 as of the date of such placement;
- ☐ A child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
- ☐ A child who is considered an alternate recipient under a Qualified Medical Child Support Order;

☐ A Dependent does not include the following:

- ☐ Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Employees have the right to choose which eligible Dependents are covered under the Plan.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- ☐ If You apply within 30 days of hire, Your coverage will become effective on your date of hire; or
- ☐ If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective July 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment provision are not considered Late Enrollees).
- ☐ If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- ☐ The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- ☐ The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- ☐ July 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 30 days following the date You acquire the Dependent; or
- ☐ If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- ☐ The date specified in a Qualified Medical Child Support Order.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Also, eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- ☐ The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- ☐ This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- ☐ The Effective Date of coverage shall be July 1 following the annual open enrollment period.

TERMINATION

Please see the COBRA section of this SPD for questions regarding coverage continuation.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- ☐ The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- ☐ The date this Plan is canceled; or
- ☐ The date coverage for Your benefit class is canceled; or
- ☐ The last day of the pay period in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- ☐ The last day of the pay period in which You retire unless this Plan provides coverage for Retired Employees. Any full-time employee who is eligible for NC Local Government Employees' Retirement System benefits, who has worked the last 15 years or more for the County of Moore and who retires, may continue medical coverage under this Plan as an alternative to COBRA until the earlier of:
  - ☐ Failing to timely pay any required premium for such coverage;
  - ☐ Retired coverage is for former employees only and does not apply to dependents.
- ☐ The last day of the pay period in which You are no longer a member of a covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section.
- ☐ The last day of the pay period in which Your employment ends; or
- ☐ The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

☐ The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

☐ The last day of the pay period in which Your coverage ends; or

☐ The last day of the pay period in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or

☐ The last day of the pay period in which Your legal spouse becomes eligible for coverage through another employer-sponsored plan which provides minimum essential coverage; or

☐ The last day of the pay period in which Your Dependent child no longer satisfies the applicable eligibility requirements provided that if coverage terminates on account of Your Dependent attaining the limiting age listed under the Eligibility section in no event will coverage terminate prior to the end of the month in which your Dependent child turns age 26; or

☐ The date Dependent coverage is no longer offered under this Plan; or

☐ The last day of the pay period in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or

☐ The last day of the pay period in which the Dependent becomes covered as an Employee under this Plan; or

☐ The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan; or

☐ The last day of the pay period in which you retire.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

☐ it has only a prospective effect;

☐ it is attributable to non-payment of premiums or contributions;

☐ it is one that you voluntarily request with a retroactive effective date;

☐ it results from your termination of employment; or

☐ it results from a dependent failing to satisfy the applicable eligibility requirements to be a dependent unless applicable law requires this to be treated as a rescission.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

NOTE: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage. Your loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time You declined coverage. The Plan will not recognize Your special enrollment right due to a loss of coverage if other coverage was not in effect at the time You declined enrollment. You declined enrollment if You do not enroll in the Plan during the Plan's annual open enrollment period, a special enrollment period or upon COBRA being offered.

You and/or Your Dependents may enroll for health coverage under this Plan due to loss of health coverage if the following conditions are met:

☐ You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

☐ You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and

☐ The coverage under the other group health plan or health insurance policy was:

- ☐ COBRA continuation coverage and that coverage was exhausted; or
- ☐ Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
- ☐ Terminated and no substitute coverage is offered; or
- ☐ No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

☐ You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

☐ Your coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact; or

☐ You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period.

You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this special enrollment period, in most cases, the coverage will become effective:

☐ In the case of marriage, on the date of the marriage; or

☐ In the case of a Dependent's birth, on the date of such birth; or

☐ In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

☐ In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or

☐ In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand your COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides you with general notice of your rights under COBRA but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You as required.

The COBRA Administrator for this Plan is FCC.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event, including the same cost of coverage. In short, a Qualifying Event plus a Loss of Coverage triggers COBRA.

Generally, You, Your covered spouse, and Dependent children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

In addition to COBRA continuation coverage, you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additional information is provided below.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
☐ Your employment ends for any reason other than your gross misconduct	up to 18 months
☐ Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "Your Right to Extend Coverage" for more information.)

If You are the spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	**Length of Continuation**
☐ Your spouse dies	up to 36 months

☐	Your spouse's hours of employment are reduced	up to 18 months
☐	Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
☐	Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
☐	You become divorced or legally separated from your spouse	up to 36 months

The Dependent children of an Employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

	Qualifying Event	**Length of Continuation**
☐	The parent-Employee dies	up to 36 months
☐	The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
☐	The parent-Employee's hours of employment are reduced	up to 18 months
☐	The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
☐	The parents become divorced or legally separated	up to 36 months
☐	The child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees is described below:

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☐	If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this can be a Qualifying Event if it results in the Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. Retired Employee	Lifetime

COBRA NOTICE PROCEDURES

About the Notice(s) You are Required to Provide Under This Summary Plan Description:

To be eligible to receive COBRA continuation coverage, Covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator:

A Qualified Beneficiary's written notice must include all the following information. (A form to notify Your COBRA Administrator is available upon request.)

- ☐ The Qualified Beneficiary's name, their current address and complete phone number,
- ☐ The group number, name of the employer that the Employee was with,
- ☐ Description of the Qualifying Event (i.e., the life event experienced), and
- ☐ The date that the Qualifying Event occurred.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee's becoming eligible for Medicare benefits (part A, part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

You must give notice in the case of other Qualifying Events that are divorce or legal separation of the employee and a spouse, a dependent child ceasing to be covered under a plan, or a second Qualifying Event. The Covered Employee or Qualified Beneficiary must provide written notice to Your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

- ☐ The date of the Qualifying Event; or
- ☐ The date on which there is a Loss of Coverage (or would lose coverage); or
- ☐ The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

Once you have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, Covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- ☐ The date Your Plan coverage terminates due to a Qualifying Event; or
- ☐ The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If You do not choose COBRA continuation coverage within the 60-day election period, Your group health coverage will end on the day of Your Qualifying Event.

When making the decision of whether to elect COBRA continuation coverage, you should keep in mind that you may have other options. Instead of enrolling in COBRA continuation coverage, there may be other

more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov or by calling 1-800-318-2596.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

Additional information is provided below.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group health coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time Your coverage under the Plan would have otherwise terminated, up to the time You make the first payment. If the initial payment is not made within the 45-day period, then Your coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however You will receive specific payment information including due dates, when You become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30-day grace period following the due date are considered timely payments.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then You will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

YOUR NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause you or your dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is **required within 30 calendar days of:**

☐ The date any Qualified Beneficiary gets married. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.

☐ The date a child is born to, adopted by, or placed for adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.

☐ The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

☐ The date any Qualified Beneficiary becomes covered by another group health plan.

☐ The date the COBRA Administrator or the Plan Administrator requests additional information from You. You must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

☐ For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)

☐ For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

- ☐ Employee's death.
- ☐ Employee's divorce or legal separation.
- ☐ Former Employee becomes enrolled in Medicare.
- ☐ A Dependent child no longer being a Dependent as defined in the Plan.

☐ For Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations: The covered retired Employee can continue COBRA coverage for the rest of his or her life.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): If you are determined by the Social Security Administration to be disabled, you may be eligible for up to 29 months of COBRA continuation coverage.

You must give the COBRA Administrator the Social Security Administration letter of disability determination within 60 days of the later of:

- ☐ The date of the SSA disability determination;
- ☐ The date the Qualifying Event occurs;
- ☐ The date the Qualified Beneficiary loses (or would lose) coverage; or
- ☐ The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Second Qualifying Events: (Dependents Only) If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or dependent children if the employee or former employees dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent. These events will only lead to the extension when the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

You must provide the notice of a Second Qualifying Event within a 60-day period that begins to run on the latest of:

- ☐ The date of the Second Qualifying Event; or
- ☐ The date the Qualified Beneficiary losses (or would lose) coverage; or
- ☐ The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- ☐ The employer ceases to maintain a group health plan for any Employees.

  (NOTE: If the employer terminates the group health plan that You are under, but still maintains another group health plan for other similarly-situated Employees, You will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- ☐ The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- ☐ After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- ☐ After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.
- ☐ The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.
- ☐ Termination for cause, such as submitting fraudulent claims.

DEFINITIONS

Qualified Beneficiary: a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, Retired Employee, the spouse of a covered Employee or the Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event: Loss of Coverage due to one of the following:

☐ The death of the covered Employee.

☐ Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).

☐ A reduction in work hours of the covered Employee.

☐ Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

☐ The covered former Employee becomes enrolled in Medicare.

☐ A Dependent child no longer being a Dependent as defined by the Plan.

☐ With respect to a Retired Employee, the Employer files bankruptcy under Title 11 of the United States Code.

Loss of Coverage: any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial loss of coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18 or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

HEALTH INSURANCE MARKETPLACE

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for Deductibles, Coinsurance, and copayments) right away, and you can see what your premium, Deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your

special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying even such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

When considering your options for health coverage, you may want to think about:

- *Premiums*: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- *Provider Networks:* If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- *Drug Formularies*: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- *Severance Payments*: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all your COBRA payments for a period of time. Keep in mind that when these payments stop, you will be required to pay the full COBRA premiums until you are allowed to enroll in the Marketplace which, in many cases, will not be until the next annual enrollment.

- *Service Areas*: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- *Other Cost-Sharing*: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- ☐ 24 months beginning on the day that the Uniformed Service leave begins, or
- ☐ a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who chose to independently elect

extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** is defined as an outside organization that has contracted with various providers to provide health care services to Covered Persons at a negotiated rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Copays, Coinsurance or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the negotiated rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out if Your provider is In-Network, please refer to the online Provider Directory at www.firstcarolinacare.com , http://providers.medcost.com/MainMenu.aspx, or call the toll-free customer service number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time. You should always call in advance to make sure that the Provider is a Participating Provider so In-Network Benefits will be paid by FCC.

☐ If a provider belongs to the following Network, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits based on the negotiated rate with the Provider:

MEDCOST PREFERRED

☐ For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits based on the Maximum Allowable Payment. A Provider may charge more than this amount for services in which case the Provider may bill the Covered Person for additional fees over and above what the Plan pays. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Maximum Allowable Payment limitations. The following exceptions may apply:

☐ Covered Services provided by an Out-of-Network Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

Provider Directory Information

The online Provider Directory lists the participating Network providers for this Plan and is available at www.firstcarolinacare.com or http://providers.medcost.com/MainMenu.aspx for each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order. The Employee should share this information with other covered

individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should contact FCC.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are Medically Necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this document. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or that a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **Allergy Testing and Treatment.**

2. **Ambulance:** Medically Necessary ground or air transportation to the nearest medically appropriate Hospital.

3. **Anesthetics and Their Administration.**

4. **Approved Clinical Trials.** The Plan covers "routine patient costs" for items and services incurred by a "qualified individual" in connection with participation in an Approved Clinical Trial. The Plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for any items or services furnished in connection with participation in an Approved Clinical Trial.

   "Routine patient costs" include all items and services that would be a Covered Expense typically under the Plan for Covered Persons who are not otherwise participating in the Approved Clinical Trial. Routine patient costs for items and services to diagnose or treat complications or adverse events arising from participation in an Approved Clinical Trial are items and services furnished in connection with participation in an Approved Clinical Trial, and accordingly, are required to be covered in accordance with Federal law if the plan typically covers such items or services for a qualified individual who is not enrolled in a clinical trial.

   Routine patient costs do not include any of the following:

   - ☐ The investigational items, devices or services themselves;
   - ☐ Items and services that are provided solely to satisfy clinical trial data collection and analysis needs and that are not used in the direct clinical management of the patient; and
   - ☐ Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

   If the Approved Clinical Trial is only offered outside the Covered Person's state of residence, the Plan will Cover routine patient costs of services and items which are provided by Non-Participating Providers. Otherwise, the Plan will not provide benefits for routine patient costs if the services are provided by a Non-Participating Provider unless the Plan otherwise covers services by Non-Participating Providers.

   To be a "qualified individual," You must meet two requirements. First, You must be eligible to participate in an Approved Clinical Trial according to the trial protocol. Second, Your attending physician must determine that your participation in the trial is appropriate, or You must provide

medical and scientific information establishing that You meet the eligibility standards of the trial protocol and that Your participation in the trial is appropriate.

NOTE: If one or more Participating Providers are participating in the Approved Clinical Trial, You must use the Participating Provider for the Approved Clinical Trial provided he or she will accept You as a patient.

5. **Artificial Limbs, Eyes, and Larynx** when Medically Necessary for Activities of Daily Living, as a result of an Illness or Injury.

6. **Augmentation Communication Devices** and related instruction or therapy.

7. **Autism Spectrum Disorder Services** for Members age 18 years or younger, screening, diagnosis and treatment of Autism Spectrum Disorder with a date of service after January 1, 2017 are Covered. Subject to the conditions listed below. Covered Services include:

   - Medically Necessary Adaptive Behavioral Treatment for a Member diagnosed with Autism Spectrum Disorder
   - For a Member diagnosed with Autism Spectrum Disorder, any of the following care, or equipment related to that care, ordered by and within the scope of the license of, a licensed physician or a licensed psychologist who determines the care to be Medically Necessary:
     - Prescription Drugs.
     - Direct or consultative services provided by a licensed psychiatrist.
     - Direct or consultative services provided by a licensed psychologist or licensed psychological associate.
     - Direct or consultative services provided by a licensed speech therapist, licensed occupational therapist, licensed physical therapist, licensed clinical social worker, licensed professional counselor, or licensed marriage and family therapists.
   - Any Medically Necessary assessments, evaluations, or tests to determine whether an individual has Autism Spectrum Disorder. Pre-certification requirements may apply.

   Coverage is subject to the Copayment, Deductible, and Coinsurance provisions stated in the Member's Schedule of Benefits that apply to primary care or specialist physician services (as appropriate to the license of the treating provider) in an office visit / outpatient setting. Coverage may not be denied on the basis that the treatments are habilitative or educational in nature. Benefits are subject to a maximum benefit of up to forty thousand dollars ($40,000) per year. Beginning in 2017 and for subsequent years, the amount shall be indexed using the Consumer Price Index for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of March of the year preceding the change divided by the index as of March 2015.

8. **Braces, Supports, Trusses, and Casts.**

9. **Cardiac Rehabilitation:**
   - ☐ Phase I, while the Covered Person is an Inpatient.
   - ☐ Phase II, while the Covered Person is Outpatient. Services generally begin within 30 days after discharge from the Hospital.

10. **Chiropractic Treatment** by a Qualified chiropractor.

11. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pregraft palatal expander.

12. **Congenital Heart Disease**: If a Covered Person is being treated for congenital heart disease and chooses to obtain the treatment at an in-network facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

13. **Cornea Transplants** are payable the same as any other Illness subject to the covered benefits provision of this Plan.

14. **Crutches** (the lesser of rental or purchase price).

15. **Dental and Oral Surgery:**
    - ☐ The care and treatment of natural teeth and gums if an Injury is sustained in an Accident, excluding implants.
    - ☐ Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the Hospital if the Covered Person is a child under five, or is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental care treatment.
    - ☐ Excision of partially or completely unerupted impacted teeth.
    - ☐ Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - ☐ Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - ☐ Reduction of fractures and dislocations of the jaw.
    - ☐ External incision and drainage of cellulitis.
    - ☐ Incision of accessory sinuses, salivary glands or ducts.
    - ☐ Frenectomy (the cutting of the tissue in the midline of the tongue).

16. **Diabetes Treatment:** The treatment of diabetes, diabetic self-management education programs, nutritional counseling and use of equipment or supplies, unless covered through the Prescription Benefits Section, are payable the same as any other Illness. Subject to the covered benefits provision of this plan.

17. **Durable Medical Equipment:** The lesser of the rental or purchase price of wheelchairs, hospital-type beds, oxygen equipment (including oxygen) and other Durable Medical Equipment, subject to the following:

    ☐ The equipment is subject to review under the Utilization Management Provision of this Plan, if applicable

    ☐ The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and

    ☐ The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item; and

    ☐ Benefits will be limited to standard models, as determined by the Plan; and

    ☐ The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medical Necessity due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and

    ☐ If the equipment is purchased, benefits may be payable for subsequent repairs or replacement only if required:

        ☐ due to the growth or development of a Dependent child,

☐ when Medically Necessary because of a change in the Covered Person's physical condition, or
☐ because of deterioration caused from normal wear and tear,

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

18. **Extended Care Facility Services:** Must be certified in advance. (Refer to the Utilization Management Section):
☐ Room and board.
☐ Miscellaneous services, supplies and treatments provided by an Extended Care Facility.

19. **Eye Diseases:** Protective lenses following a cataract operation.

20. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

☐ Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
☐ Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

21. **Gender Reassignment Surgery.** The Plan Covers Gender Reassignment Surgery when:

☐ The Member's condition meets FCC's clinical guidelines for such surgery;
☐ The Member has not previously received such gender reassignment surgery (regardless of whether or not the individual was a Member at the time of such surgery); and
☐ The type of gender reassignment surgery proposed is not Experimental/Investigational, as determined by FCC.

The benefit limit for Covered gender reassignment surgery is once per lifetime.

22. **Hearing Services** include:

☐ Exams, tests, services and supplies, including Preventive Care, to diagnose and treat a medical condition.
☐ Purchase or fitting of hearing aids.
☐ Implantable hearing devices.

23. **Home Health Care Services:** (Refer to Home Health Care section).

24. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

☐ **Assessment:** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
☐ **Inpatient Care:** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part- time Home Health Care services.
☐ **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
☐ Covered Person must be Terminally Ill with an anticipated life expectancy of about six months.

Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

25. **Hospital Services (Includes Inpatient Services, Surgical Centers and Birthing Centers):**
    - ☐ Semi-private room and board. For network charges, this rate is based on networking repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary.
    - ☐ Intensive care unit room and board.
    - ☐ Miscellaneous and ancillary services.
    - ☐ Blood, blood plasma and plasma expanders, when not available without charge.

26. **Hospital Services (Outpatient).**

27. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

28. **Infusion Therapy** (including drugs) and other non-self-injectibles. The Covered Member's cost-sharing with respect to infusion therapy will depend on where the service is received. If it is received in a physician's office, it will be covered as a physician specialist office visit, and if it is received in an outpatient facility, it will be covered as an outpatient visit.

29. **Laboratory and Pathology Tests** for covered benefits.

30. **Maternity Benefits** for Covered Persons include:

    - ☐ Prenatal and postnatal care.
    - ☐ Hospital room and board.
    - ☐ Obstetrical fees for routine prenatal care.
    - ☐ Vaginal delivery or Cesarean section.
    - ☐ Medically Necessary diagnostic testing (such as ultrasound and amniocentesis).
    - ☐ Outpatient Birthing Centers.

31. **Mental Health Treatment** (Refer to Mental Health section).

32. **Nursery and Newborn Expenses Including Circumcision**, are covered for the employee's or covered spouse's natural (biological) children only.

    If a newborn has an Illness, suffers Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other Covered Expense if coverage is in effect for the baby.

33. **Orthotic** appliances, devices, and custom molded shoe inserts, including the exam for required prescription and fitting.

34. **Oxygen and Its Administration.**

35. **Pharmacological Medical Management** (medication management and lab charges).

36. **Physician Services** for covered benefits.

37. **Prosthetic Devices.** The initial purchase fitting repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

☐ Due to the growth or development of a Dependent Child; or
☐ When necessary because of a change in the Covered Person's physical condition; or
☐ Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

38. **Radiation Therapy and Chemotherapy.**

39. **Radiology and Pathology Interpretation Charges.**

40. **Reconstructive Surgery:**
☐ Following a mastectomy (Women's Health and Cancer Rights Act)
The Covered Person must be receiving benefits in connection with a medically necessary mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
☐ Surgery to restore bodily function and correct deformity resulting from a congenital Illness or anomaly, Accident, or from infection or other disease of the involved part.

41. **Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

☐ Evidence-based items or services that have in affect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
☐ Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
☐ With respect to infants, Children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
☐ With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Additional information regarding coverage of Routine Care is provided in the Schedule of Benefits.

42. **Second Surgical Opinion** must be given by a board-certified specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

43. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits section in this SPD) in connection with treatment for male or female impotence.

44. **Sleep Disorders** if Medically Necessary.

45. **Sleep Studies.**

46. **Sterilizations (voluntary).**

47. **Substance Abuse Disorder Services** (Refer to Mental Health and Substance Abuse Disorder Benefits section).

48. **Surgery and Assistant Surgeon Services** if determined Medically Necessary by the Plan. For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Maximum Allowable Payment fee allowance for the primary procedure, and fifty percent (50%) of the Maximum Allowable Payment fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

49. **TeleMedicine:** Remote delivery of non-emergency medical services, such as health assessments and consultations, while the patient and Provider interact over a secure video conferencing infrastructure. TeleMedicine allow Providers to evaluate, diagnose and recommend treatment without the need for an in-person visit. This includes medical exams and consultations as well as behavioral health, including Substance Use Disorder evaluations and treatment.

    Non-Covered Telemedicine Services include, but are not limited to, communications used for:
    ☐ Telemedicine that occurs the same day as an in-person visit when performed by the same Provider.
    ☐ Telemedicine services when the originating (patient) and distant (provider) site locations are the same location.

    Patient communications incidental to the evaluation and management visit, counseling, or other covered medical services, including but not limited to:
    - Reporting normal lab or other test results
    - Office appointment requests
    - Billing, insurance coverage or payment questions
    - Requests for referrals to doctors outside the online care panel • Benefit precertification
    - Physician-to-Physician consultation

50. **Temporomandibular Joint Disorder (TMJ) Services** includes**:**

    ☐ Diagnostic services.
    ☐ Surgical treatment.
    ☐ Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

51. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    ☐ **Occupational therapy**.
    ☐ **Physical therapy**.
    ☐ **Respiratory therapy**.
    ☐ **Aquatic therapy**.
    ☐ **Massage therapy**.

☐ **Speech therapy**.

The therapy must be provided by a qualified Provider, such as a medical doctor, doctor of osteopathy, physical therapist, chiropractor, podiatrist or occupational therapist (subject to satisfaction of any applicable licensure requirements).

The Plan allows coverage for occupational, physical, or speech therapy for Developmental Disorders such as Autism Spectrum Disorder (subject to applicable limits), Downs Syndrome, Cerebral Palsy and other Developmental Disorders.

This Plan does not cover services that should legally be provided by a school.

52. **Transplant Services** (Refer to Transplant section).

53. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment. One wig, toupee, hairpiece is covered, limited to $350 for one wig, toupee, or hairpiece per lifetime.

54. **X-Ray Services** for covered benefits.

WOMEN'S PREVENTIVE CARE

Women's Preventive Care is covered at 100%.

(Benefits below apply to services provided by an In-Network provider and must be billed with a primary diagnosis of preventive, screening, counseling or wellness.) For additional information regarding coverage of Women's Preventive Care, refer to the Schedule of Benefits.

With respect to the following contraceptive methods, the Plan will cover at 100% at least one item of each method for a female member of reproductive capacity*:

- Cervical Caps
- Diaphragms and sponges
- Implantable rods
- IUDs
- Condoms and spermicide
- Emergency contraception medication
- Medroxyprogesterone 150mg injection (generic only)
- Oral Contraceptives
- Patch (thirty day supply)
- Vaginal contraceptive ring (thirty day supply)
- Surgical sterilization
- Surgical sterilization implant

Surgical sterilization is a covered benefit for women with reproductive capacity; however, hysterectomies are excluded as they are not performed primarily for sterilization.

* Includes only FDA-approved contraceptives that are obtained from a participating pharmacy or a participating mail order pharmacy and that are considered preventive care under the federal preventive care guidelines. This includes generic contraceptives plus brand-name contraceptives (but only if a generic is not available or the brand-name is medically necessary as determined by your physician).

Certain screenings, preventive care and counseling services for women are covered at 100%, including:

- Annual wellness preventive visit for adult women. (Additional visit if physician determines it is medically necessary)
- Annual screening and counseling for interpersonal and domestic violence for women
- Breastfeeding support and counseling for pregnant and postpartum women
- Breastfeeding supplies for pregnant and postpartum women as below:
    - ❖ One electric or manual breast pump per pregnancy is covered if purchased from a participating durable medical equipment provider. (Hospital grade pumps are excluded and not covered).
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Human papilloma virus (HPV) DNA testing for women 30 or older every three years
- Annual HIV screening and counseling for sexually active women
- Counseling on sexually transmitted infections (STIs) for women who are sexually active.
- Education and counseling on contraceptive methods and sterilization procedures for women with reproductive capacity.
- Genetic counseling and evaluation for BRCA testing for women who have a family or personal history of breast, ovarian, tubal, or peritoneal cancer as they are associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. If indicated after counseling, the BRCA testing will be covered when medically necessary criteria are met.

For additional information, please refer to the Schedule of Benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by FCC. You must be certified in advance by FCC before receiving services. Please refer to the Utilization Management section for more details. Covered services that are Medically Necessary include:

- ☐ Home visits that are in lieu of visits to the provider's office, and that do not exceed the Maximum Allowable Payment to perform the same service in a provider's office.
- ☐ Intermittent Nurse Services. Benefits paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- ☐ Nutrition counseling provided by or under the supervision of a registered dietitian.
- ☐ Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- ☐ Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- ☐ Homemaker or housekeeping services except as ordered in the Hospice treatment plan.
- ☐ Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- ☐ Services performed by family members or volunteer workers.
- ☐ "Meals on Wheels" or similar food service.
- ☐ Separate charges for records, reports or transportation.
- ☐ Expenses for the normal necessities of living such as food, clothing and household supplies.
- ☐ Legal and financial counseling services.

TRANSPLANT BENEFITS

Refer to the Utilization Management section of this document for prior authorization requirements

DEFINITIONS

Approved Transplant Services: services and supplies for certified transplants when ordered by a Physician and provided by a FACT Accredited Facility. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and ancillary services.

FACT Accredited Facility: a facility which has been accredited with the Foundation for Accreditation of Cellular Therapy (FACT).

Organ and Tissue Acquisition/Procurement: the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person for Approved Transplant Services, subject to any Deductibles, Copays, Coinsurance, or maximums or limits shown on the Schedule of Benefits or described in this document. Benefits are based on the Maximum Allowable Payment or the Plan's negotiated rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual plan language. The approved transplant and medical criteria for such transplant must be considered Medically Necessary, and medically appropriate for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or stem cell transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

☐ Kidney.
☐ Kidney/Pancreas.
☐ Pancreas, which meets the criteria as determined by the Utilization Management.
☐ Liver.
☐ Heart.
☐ Heart/Lung.
☐ Lung.
☐ Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
☐ Small Bowel

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by a FACT Accredited Facility, the Plan will allow them to go to a second FACT Accredited Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISION FOR TRAVEL EXPENSES

If a transplant is performed at an in-network FACT Accredited Facility, and the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for the following, up to the maximum listed on the Schedule of Benefits:

☐ Transportation to and from the facility for:

  ☐ The Covered Person; and

    - One or two parents of the Covered Person (if the Covered Person is a Dependent child, as defined in this Plan); or
    - An adult to accompany the Covered Person;

  ☐ Living donor if the donor lives more than 50 miles from the transplant facility.

☐ Lodging at or near the facility for the living donor, Covered Person and/or adult(s) who accompanied the Covered Person while the Covered Person is receiving transplant- related services at such transplant facility. Lodging for purposes of this Plan does not include private residences.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the facility.

Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- ☐ Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- ☐ Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be a transplant benefit approved by the Plan.
- ☐ Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- ☐ Transplants considered Experimental, Investigational or unproven, except for Approved Clinical Trials.
- ☐ Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.
- ☐ Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the NCCN compendium.
- ☐ Expenses related to the purchase of any organ.

PRESCRIPTION BENEFITS

DEFINITIONS

Brand Drug: an original or innovator prescription drug product, approved by the U.S. FDA (Food and Drug Administration) through the New Drug Application process.

Generic Drug: a Prescription Drug that is considered by the FDA to be therapeutically equivalent or substitutable with a specific brand name prescription drug. The generic contains the same strength, dosage, dosage form, active ingredient(s), and intended uses as its brand name counterpart.

Non-Participating Pharmacy: any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Manager and is excluded from the network of pharmacies.

Participating Pharmacy: any retail or mail order pharmacy that is contracted by Pharmacy Benefits Manager to be included in a network of pharmacies at a contracted amount.

Pharmacy: a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Manager: an organization that manages payment for Prescriptions and services under the Plan.

Preferred Brand: a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of Prescription Drug benefits under the Plan.

Prescription Drug: a product approved as a drug by the U.S. FDA that under federal or state law requires a prescription from a licensed physician or other legally authorized prescriber to be dispensed by a pharmacy. Drugs that are available without a Prescription are considered Over-the-Counter (OTC).

Prior Authorization: the process of obtaining a certification of medical necessity for Restricted Access prescription Drugs or Devices or quantities of certain Prescription drugs before they are dispensed using guidelines approved by FCC.

Restricted Access Prescription Drugs or Device: those covered prescription drugs or devices that require prior authorization or the use of alternative drugs or devices (step therapy) in order to be covered.

Prescription Benefits:

NOTE: FDA approval of a drug does not guarantee inclusion as a covered item under the Prescription Drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some Prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved Prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

Prescription Drugs are eligible for coverage ("Covered Drugs") under Prescription Drug Benefits when prescribed by an authorized, licensed healthcare provider and dispensed by a licensed pharmacist for self-administration or consumption at home ("Outpatient Prescription Drugs") Exclusions, prior authorization, other coverage rules, copayments and other limitations apply as outlined in the Schedule of Benefits..

A Covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or Physician.

To the extent required by federal law, certain preventive care drugs (as determined by FCC's Pharmacy Benefit Manager, MedImpact, in accordance with federal law) are not subject to a copay or deductible. Preventive care drugs include, in certain circumstances, aspirin and iron supplements. For a

list of the preventive care drugs covered by this provision, visit the MedImpact Member website at www.mp.medimpact.com or call (800) 788-2949.

The Prescription Drug Program also provides certain preventive care and contraception at no cost, as required by federal law. Specifically, certain FDA-approved contraceptives that are obtained from a participating pharmacy or a participating mail order pharmacy and that are considered preventive care under the federal preventive care guidelines are paid at 100%. This includes generic contraceptives plus brand-name contraceptives (but only if a generic is not available or the brand-name is medically necessary as determined by your physician). For additional information, refer to the section regarding Women's Preventive Care.

Contact MedImpact directly if you have questions about specific preventive care and contraceptive items that are covered with no cost-sharing, including amount limits and types, such as emergency contraception, injectable drugs, implantable devices, oral contraception and barrier contraception.

The following are **excluded** from coverage under the Prescription Benefits (This list is **not** all-inclusive):

- ☐ Applicable exclusions listed under General Exclusions section of this SPD.
- ☐ Prescription products if a prior authorization was necessary but not received or denied.
- ☐ Prescription products that are available over-the-counter, except those specifically authorized by the Plan to be covered if dispensed by prescription.
- ☐ Prescription products that are not approved by the FDA that do not have FDA approval for the purpose for which prescribed.
- ☐ All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- ☐ Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- ☐ Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.
- ☐ Take home drugs filled by a Hospital or Physician's Office.
- ☐ Except where required by law, medications that are to be administered in a physician's office, clinic, hospital, other healthcare settings are not covered under Prescription Benefits. Coverage may be available under Medical benefits.

The Covered Person has a right to purchase an excluded product at his or her own cost if the product is excluded under this Plan.

NOTE: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

FOR MORE INFORMATION ON PRESCRIPTION BENEFITS

For more information about these Prescription benefits, please call the Pharmacy Benefits Manager, MedImpact, at (800) 788-2949, or visit the MedImpact website at www.mp.medimpact.com or the FCC website at www.firstcarolinacare.com.

MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician or Behavioral Health Provider and deemed to be Medically Necessary for the treatment of Mental Health Disorders or Substance Abuse Disorders, subject to any Deductibles, Co-pays, Coinsurance, maximum or limits shown on the Schedule of Benefits or described in this document. Benefits are based on the Maximum Allowable Payment, maximum fee schedule or the negotiated rate, as applicable.

COVERED BENEFITS

Covered Expenses are:

Inpatient Services: Inpatient room and board are covered at the semi-private room and board during your stay in a Hospital or a Residential MHSA Treatment Center. For in-network services, this rate is based on networking repricing. For non-network services, any charge over a semi-private room charge will not be covered unless deemed by the Plan to be Medically Necessary.

Residential MHSA Treatment Center: Residential MHSA Treatment Center services, including but not limited to room, board and supplies, if the Member's Provider recommends the services and certifies that the Member needs 24-hour care.

Partial Hospitalization: a treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services: Outpatient treatment received while not confined as an inpatient in a Hospital or Residential MHSA Treatment Center from a Physician or Behavioral Health Provider.

UTILIZATION MANAGEMENT
And Other Medical Management Services

Utilization Management is the process of evaluating whether services, supplies or treatment are Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can eliminate unnecessary services, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Plan may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring that an approved authorization is on file prior to having services performed that require and authorization. No authorization on file may result in either a claim denial or a penalty being applied. Covered Persons should call the phone number on the back of the Plan identification card if they have not received an approved authorization letter in the mail prior to the service date. It is typical for providers to submit authorization requests on your behalf, however it is recommended that requests for Prior Authorization are submitted at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

SPECIAL NOTES: The Covered Person will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Prior Authorization requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **FirstCarolinaCare Insurance Company ("FCC")**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management: an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- ☐ Inpatient stay in a Hospital or Extended Care Facility.
- ☐ Organ and tissue transplants

- ☐ Stem Cell Transplants
- ☐ Genetic Testing
- ☐ Home Health Care
- ☐ Durable Medical Equipment over $1,500 or any Durable Medical Equipment rentals over $500/month.
- ☐ Prosthetics over $1,000.
- ☐ Gender reassignment surgery
- ☐ All Inpatient stays in a Hospital or Residential MHSA Treatment Center and Partial Hospitalization for Mental Health Disorders and Substance Abuse Disorders.
- ☐ Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

NOTES:

1. **If a Covered Person receives Prior Authorization for one facility, but then the person is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).**
2. **A penalty of $300 will be applied to applicable claims if a Covered Person receives services but did not obtain the required Prior Authorization.**

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

Even though the Utilization Review Organization provides a Prior Authorization to a Covered Person, it does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all the provisions described in this SPD.

Medical Director Oversight. FCC's medical director supervises the entire concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine the best course of action and will reach out to the member's Physician for a peer-to-peer discussion, if necessary.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Other Medical Management Services

Maternity Management provides education to members with a high-risk pregnancy to help mothers carry their babies to term. This program increases the number of healthy, full term deliveries and decreases the cost of a long-term hospital stay for both the mother and/or baby. Program members are contacted via telephone by nurses with extensive obstetrics neonatal experience. A comprehensive assessment to determine the member's risk level and educational need is done at that time. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members with a high-risk pregnancy can self-refer by calling FCC's toll-free number 1-800-574-8556.

Nurse Helpline service is a 24-hour, toll-free health information line that assists Covered Persons with medical-related questions and concerns. Nurse Helpline gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents. Nurse Helpline offers Covered Persons access to valuable health information via the health education library (1,100 recorded topics with over 600 in Spanish) and triage services. The triage services are a primary tool to guide the nurse's thought process and provide credible, consistent and accurate information to the caller to help educate them on specific conditions and treatment options. All a Covered Person needs to do is call the Nurse Helpline at 1-800-336-2121.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. The Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of the total allowable expenses incurred during the remainder of the claim determination period.

The Plan will coordinate benefits with the following types of medical or dental plans:

- ☐ Group health plans, whether insured or self-insured.
- ☐ Hospital indemnity benefits in excess of $200 per day.
- ☐ Specified disease policies.
- ☐ Foreign health care coverage.
- ☐ Medical care components of group long-term care contracts such as skilled nursing care.
- ☐ Medical benefits under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details (below).
- ☐ Medical benefits under homeowner's insurance policies.
- ☐ Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- ☐ The plan that has no coordination of benefits provision is considered primary.
- ☐ When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – No-Fault State in this SPD for more details.
- ☐ The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.
- ☐ The plan that covers a person as a Dependent (or beneficiary) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).
- ☐ When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
- ☐ If one or more plans cover the same person as a Dependent child:
  - ☐ The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married; or
- The parents are not separated (whether or not they have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the plan that covered either of the parents longer is primary.

☐ If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

☐ If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the non-custodial parent; and then
- The plan of the spouse of the non-custodial parent.

☐ Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary.

☐ Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. (See exception in the Medicare section.)

☐ Longer or Shorter Length of Coverage: The plan that covered the person as an Employee, member, subscriber or retiree longer is primary.

☐ If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member or subscriber is considered primary.

☐ If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. The Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of the total allowable expenses incurred during the remainder of the claim determination period.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

☐ This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:

- ☐ You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
- ☐ For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.

☐ Medicare generally pays first (has primary responsibility) under the following circumstances:

- ☐ You are no longer actively employed by an employer; and
- ☐ You or Your spouse has Medicare coverage due to Your age, plus You also have COBRA continuation coverage through the Plan; or
- ☐ You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
- ☐ You or Your covered spouse have coverage under a retiree plan plus Medicare coverage; or
- ☐ Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (NOTE: If a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

☐ Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The 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 this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

Covered Persons are being provided benefits pursuant to this group health Plan. This Plan is designed to cover You and Your Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any payments or benefits You or Your Dependent(s) have or may recover from any Other Party when charges are Incurred as the result of an Accident, Illness, Injury or other medical condition caused by an act or omission of said Other Party. Benefits under this Plan are excluded subject to the terms and conditions of this Subrogation, Reimbursement and Offset Provision anytime there is another Party who is liable or responsible (legally or voluntarily) to make payments in relation to the Accident, Illness or Injury.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- ☐ The party or parties that caused the Accident, Illness, Injury or other medical condition;
- ☐ The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- ☐ The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers or home-owner's insurance;
- ☐ A worker's compensation or school insurer;
- ☐ Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

For purposes of this section, **Recovery** is defined to include, but is not limited to, any amount paid or payable by another Party through a settlement, judgment, mediation, arbitration, or other means in connection with an Accident, Injury or Illness.

This section is applicable when a Covered Person and/or his or her Dependent(s) have incurred charges for an Accident, Illness, Injury or other medical condition in connection with an act or omission of any Other Party. If the Covered Person and/or his or her Dependent(s) have the legal right to seek a Recovery from such Other Party, benefits will only be payable if You and Your Dependents agree to the following:

- ☐ That the Plan is subrogated to all rights the Covered Person may have, and You and Your Dependents acknowledge that the Plan will have a first priority lien and right of recovery, on any Recovery received from any Other Party as a result of an Accident, Illness, Injury or other medical condition caused by an act or omission of the Other Party. Any Covered Person accepting benefits from the Plan assigns from any such Recovery an amount equal to the benefits paid by the Plan. A Covered Person further agrees that notice of this assignment presented to the Covered Person's attorney and/or insurance company or Other Party responsible for payment of the damages is binding on the party receiving such notice.

- ☐ That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or his or her Dependent(s) or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.

- ☐ If an act or omission of another Party causing an Accident, Illness or Injury results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments.

- ☐ That, if requested, the Covered Person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else is necessary to protect the Plan's rights. Such documents may require the Covered Person to direct their attorney (and other representatives) in writing to retain separately from any Recovery that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such

agreement and to pay such money to the Plan. Failure or refusal to execute such documents or agreements or to furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party, such agreement is expressly incorporated in this Plan and will be provided to the Covered Person at any time upon request.

☐ The Plan is also granted a right of reimbursement from the proceeds of any Recovery obtained or that may be obtained by the Covered Person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the Plan's subrogation and lien rights described above. A Covered Person shall promptly convey to the Plan any amounts received from any Recovery for the reasonable value of the medical benefits advanced by the Plan or provided by the Plan to the Covered Person.

☐ In the event that the Covered Person fails to cooperate with the Plan or fails to comply with the terms of this provision, the Plan may offset or otherwise reduce present or future benefits otherwise payable to the Covered Person or their Spouse or Dependent under the terms of the Plan. Moreover, in the event that a Covered Person fails to cooperate with the Plan, the Covered Person shall be responsible for any and all costs Incurred by the Plan in enforcing its rights, including but not limited to attorney's fees.

☐ That the Plan has a right to recover, through subrogation, reimbursement, offset or through any other available means the following:

- ☐ Any amount from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and
- ☐ Any overpayments made directly to providers on behalf of the Covered Person for the Accident, Illness, Injury or other medical condition.

☐ That the Plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the Plan and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.

☐ That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.

☐ That the Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.

☐ That the Covered Person or their legal representative or Guardian, shall be considered a constructive trustee with respect to any Recovery received or that may be received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits. Any such funds will be held in trust until the Plan's lien is satisfied.

☐ The Plan's rights apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.

☐ That the Plan reserves the right to independently pursue and recover paid benefits.

☐ The Plan's Subrogation, Reimbursement and Offset provisions apply to a Recovery obtained by the Covered Person in connection with an Accident, Injury or Illness without regard to the description, name or label applied to the Recovery.

☐ The Plan's right of reimbursement and subrogation shall apply without regard to any equitable defenses that a Covered Person or his or her spouse or Dependents assert or may be entitled to assert, including without limitation any defense of unjust enrichment.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered benefits under this Plan and will not be considered for payment.

The Plan does not pay for Expenses incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section when the Plan has information that the Illness or Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Charges for elective abortion.

2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment.**

4. **Adaptive Behavioral Treatment** except Medically Necessary Adaptive Behavioral Treatment for Members diagnosed with Autism Spectrum Disorder.

5. **Alopecia:** Wigs, Toupees, Hairpieces, Hair Implants, Cranial Hair Prosthesis, Transplants or Hair Weaving, worn for hair loss suffered as a result of alopecia, unless covered elsewhere in this document.

6. **Alternative Treatment:** Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.

7. **Appointments Missed:** An appointment the Covered Person did not attend.

8. **Aquatic Therapy** unless provided by a Qualified physical therapist.

9. **Assistance with Activities of Daily Living.**

10. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

11. **Atomic Explosions or Nuclear Energy:** Illness or Injury caused by or arising out of atomic explosions or nuclear energy, whether or not the result of war.

12. **Before and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends are not covered.

13. **Blood:** Blood donor expenses.

14. **Breast Reductions:** unless determined Medically Necessary by the Plan.

15. **Cardiac Rehabilitation** beyond Phase II.

16. **Charges In Excess of Maximum Allowable Payment:** The difference between the Maximum Allowable Payment and the actual charges of a Physician or Hospital.

17. **Chelation Therapy,** except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

18. **Close Relative:** Charges for the services of any person who is a member of the participant's immediate family or who ordinarily resides in the participant's home.

19. **Cosmetic Treatment**, **Cosmetic Surgery:** Charges incurred in connection with cosmetic surgery except to correct a condition resulting from a non-occupational traumatic injury, and when the charges are incurred within two (2) years of said traumatic injury; or except when Medically Necessary to

correct a congenital anomaly of a Dependent Child; or except to correct a symmetry disparity condition within two (2) years following breast reconstruction surgery due to a mastectomy.

20. **Counseling Services** in connection with marriage, pastoral or financial counseling.

21. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of Driving While Intoxicated classes or other classes ordered by the court.

22. **Criminal Activity:** Health services for injury sustained while a Member is engaged in or participating in an act that results in a conviction as a misdemeanor or felony by an appropriate law enforcement agency. This exclusion does not apply if the Covered Person is the victim of an injury resulted from an act of domestic violence or a medical condition (whether a physical or mental medical condition). Charges may be held until final judicial proceedings are complete.

23. **Custodial Care.** Charges incurred for hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an actual sickness or Injury; or charges for custodial or domiciliary care, for rest cures, or for weight reduction. This exclusion includes, but is not limited to, charges for services, treatment or supplies in a facility, or part of a facility, that is mainly a place for (a) rest, residence or assisted living; (b) convalescence; (c) custodial care; (d) the aged; or (e) training or schooling. This exclusion does not apply to services that meet the terms and conditions described under the Plan's general rules for coverage, which will be Covered Services under the same terms and conditions as would apply if the member were residing in a private living space.

24. **Dental:** Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be paid for charges incurred for dental treatment required because of:

    ☐ Injury to natural teeth due to an accident when said accident occurred within one year prior to said treatment; or

    ☐ Dental treatment required because of medical care (such as x-ray treatment for oral cancer or chemotherapy) (this shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture unless covered elsewhere in this Plan)

25. **Disorders:** Occupational, physical, and speech therapy services related to intellectual disability or behavioral therapy, unless covered elsewhere in this document. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

26. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

27. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.

28. **Employment Or Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person 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.

29. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

30. **Experimental Or Investigational:** Expenses for Experimental or investigative drugs, devices, medical treatment, or procedures. This exclusion will not be construed to deny otherwise eligible

expenses for Medically Necessary treatment of breast cancer by high-dose chemotherapy in conjunction with an autologous or allogenic bone marrow transplant or peripheral stem cell transfusion. This exclusion also does not apply to Approved Clinical Trials

31. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

33. **Foot Care (Podiatry):** Routine foot care including treatment of corns, calluses and toenails, unless covered as a medically necessary service for the treatment of diabetes.

34. **Foreign Travel:** Charges for medical or hospital services, medical or hospital supplies, or prescription drugs for a Covered Person incurred in a foreign country where the primary purpose of such foreign travel was to obtain such medical care or hospital care.

35. **Genetic Counseling** regardless of purpose, unless covered elsewhere in this Plan.

36. **Genetic Testing**, unless covered elsewhere in this Plan, if:
- Testing is experimental or investigational.
- Testing is not considered standard of care, such as the clinical diagnosis can be made without the use of a genetic test.
- Testing is not clinically appropriate for the patient's condition/disease, for example, when it will not change diagnosis and/or management. Other situations where testing is not clinically appropriate include, but are not limited to:
    - Testing is performed entirely for non-medical (e.g., social) reasons.
    - Testing is not expected to provide a definitive diagnosis that would obviate the need for further testing.
    - Testing is performed primarily for the convenience of the patient, physician or other health care provider.
    - Testing would result in outcomes that are equivalent to outcomes using an alternative strategy, and the genetic test is more costly.

37. **Habilitative Services** including vocational or industrial rehabilitation services or work hardening.

38. **Home Deliveries.**

39. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

40. **Hypnotism.**

41. **Illegal Controlled Substance:** Charges incurred for injuries sustained as the result of an illegal controlled substance.

42. **Impairment-Related Injuries:** (Includes Driving While Impaired, (DWI): An additional $1,000 copay will apply if impairment due to alcohol and/or controlled substance was a contributing cause of the Participant's or covered dependent's injuries. Benefits will apply if such person's conduct was not a cause of the injuries. This provision does not change any exclusion or limitation of this plan.

43. **Implanted Devices** for control of pain in excess of one (1) device, internal battery replacement and/or implantation per benefit year.

44. **Infant formula** not administered through a tube as a sole source of nutrition for the Covered Person.

45. **Infertility Treatment:**

- ☐ Surgical reversal of a sterilized state which was a result of a previous surgery.
- ☐ Embryo transfer.
- ☐ Freezing or storage of embryo, eggs, or semen.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered Person.

46. **Lamaze Classes** or other child birth classes.

47 **Lasik Surgery** or similar surgery used to improve eye sight.

48. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

49. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

50. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this document.

51. **Massage Therapy** unless provided by a Qualified chiropractor or physical therapist.

52. **Military:** A military related Illness or Injury to a Covered Person on active military duty.

53. **Nicotine:** Services, treatment or supplies related to addiction to or dependency on nicotine unless covered elsewhere in this Plan

54. **No-Fault State:** Benefits are not payable under this Plan for any Illness or Injury received in an Accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under no-fault have been exhausted.

55. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards.

56. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

57. **Nursery and Newborn Expenses** for grandchildren of a covered employee or spouse unless he or she qualifies as an eligible Dependent child.

58. **Nutrition Counseling** unless covered elsewhere in this document.

59. **Orthognathic, Prognathic and Maxillofacial Surgery.**

60. **Orthotics** for non-custom molded shoe inserts.

61. **Over-The-Counter Medication, Products or Supplies** except as provided in the Prescription Benefit Provision.

62. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

63. **Prescription Medication:** other than those administered while in a Hospital or Physician's office as part of treatment. (See Prescription Benefits section for information on medications covered for use at home).

64. **Private Duty Nursing Services.**

65. **Radial Keratotomy Or Refractive Keratoplasty:** Radial keratotomy and other refractive keratoplasty procedures.

66. **Reconstructive Surgery:** Charges incurred in connection with cosmetic surgery except to correct a condition resulting from a non-occupational traumatic Injury, and when the charges are incurred within two (2) years of said traumatic Injury; or except when Medically Necessary to correct a congenital anomaly of a Dependent Child; or except to correct a symmetry disparity condition within two (2) years following breast reconstruction surgery due to a mastectomy.

67. **Resident or Intern:** Charges for any resident or intern of a hospital.

68. **Return To Work/School:** Telephone consultations or completion of claim forms or forms necessary for the return to work or school.

69. **Reversal Of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

70. **Reversal of gender reassignment surgery.**

71. **Room And Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

72. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

73. **Services At No Cost:** Charges incurred for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present services 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 Covered Person is not required to pay.

74. **Services, treatment or supplies** related to sexual deviation. Sexual deviation, sometimes called paraphilia disorders, are disorders of deviant sexuality. As defined in the Diagnostic and Statistical Manual of Mental Disorders, they involve recurrent fantasies, fetishes, urges or behaviors of a sexual nature that center around children, non-humans (animals, objects, materials), or harming others or one’s self. Gender identity disorder is not considered sexual deviation.

75. **Supplements:** Any nutritional substance, whether in liquid or solid form, including any supplement, infant formula, non-infant nutrition formula, meal replacement product, or medical food, regardless of whether or not the substance is administered orally or through a feeding tube. This exclusion applies to megavitamin regimens and orthomolecular therapy. This exclusion does not apply to total parenteral nutrition delivered in accordance with the General Coverage Rules.

76. **Surrogate Motherhood Expenses.**

77. **Taxes:** Sales taxes, shipping and handling.

78. **Telemedicine or Telephone Consultations.**

79. **Third Party Liabilities:** Any Covered Expenses 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.

80. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

81. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

82. **Vision Care** unless covered elsewhere in this document.

83. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Prenatal Vitamins, Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

84. **Vocational Testing, Evaluation and Counseling:** Vocational and educational services rendered primarily for training or education purposes.

85. **Warning Devices:** Warning devices, stethoscope, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring.

86. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

87. **Wigs, Toupees, Hairpieces, Cranial Hair Prosthesis, Hair Implants, Transplants, or Hair Weaving, or** any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this document.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Participation level, with the Covered Person being responsible for a larger percentage of the total medical expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. FCC will normally send payment for Covered Expenses directly to the Covered Person's provider.

CLAIM AND APPEAL PROCEDURES

How to Obtain Benefits

Participating Providers will submit claims to FCC on the Member's behalf. Non-Participating Providers may require payment at the time of service and the Member may be responsible for filing the claim. When submitting a Claim for services provided by a Non-Participating Provider, Members must submit copies of bills for all charges. Member Reimbursement Claim Forms may be obtained from FCC or may be downloaded from FCC's website at http://www.firstcarolinacare.com/members/forms.htm.

Certain Non-Participating Providers to which a Member cannot assign benefits provided under this Plan may be identified from time to time. If a Member receives Covered Services from these Providers, payment will be issued to the Member rather than to the Provider, even if a Member has authorized benefits to be assigned to the Provider.

Member Claim Submission

A completed Member Reimbursement Claim Form and the Provider's statement of charges must be submitted to FCC at the address below:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Attn: Claims

Time Limit for Claims Submission

The Member or the Provider must submit 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 Covered 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. The 1-year extension, if applicable, does not require the Plan to make payments to Participating Providers whose participation agreements allow a shorter period in which to file claims. However, the 1-year extension stated in this paragraph will be applied to any claims filed by Members for Covered Services rendered by Non-Participating Providers.

Claims Procedures

According to federal law governing this Plan, there are two types of claims that may be decided by FCC: Pre-service Claims and Post-service Claims. A Pre-service Claim is a claim that requires approval of the benefit before receiving medical care. A Post-service Claim is a claim for benefits after services have already been provided. The timeframe for decisions on Pre-service Claims and Post-service Claims are different. Moreover, Pre-service Claims may be handled differently based upon whether the claim is an urgent care claim.

A different procedure applies to claims and appeals regarding prescription drug benefits and coverage. This procedure is administered by MedImpact and is described in more detail below.

Procedures for Pre-Service and Urgent Care Claims

FCC shall notify the Member of the decision regarding a Pre-service Claim (whether adverse or not) within a reasonable period of time but not later than 15 days after receipt of a properly completed Pre-service Claim, unless the request is expedited, as described below.

This period may be extended one time for up to 15 days if FCC determines that the extension is necessary due to matters beyond the control of the Plan and properly notifies the Member of the extension prior to the expiration of the initial 15-day period. The extension notice shall include the circumstances requiring the extension and the expected date of the determination. If the extension is requested because of the need for additional information, FCC will notify the claimant of the needed information within the initial 15-day period and pend the claim until the information is received. The Member will be given 45 days after receipt of the notice to provide the requested information. Within 15 days of its receipt of the requested information, FCC shall notify the Member of its determination. If the Member fails to timely provide the requested information, FCC will notify the Member of its determination within 15 days after the expiration of the time to provide the information.

Members have the right to a more rapid or expedited decision on a Pre-service Claim if it is an urgent care claim. An urgent care claim is a claim with respect to which following the standard time limits would:

- Seriously jeopardize the life or health of the Member,
- Seriously jeopardize the Member's ability to regain maximum function, or
- Would subject the Member to severe pain that cannot be adequately managed without the services subject to the request, in the opinion of a prudent layperson with an average knowledge of health and medicine, or in the opinion of a Physician with knowledge of the Member's condition.

In these cases, FCC will give the Member a decision (whether adverse or not) as soon as possible, taking into account the medical situation, but not later than 72 hours after FCC received the request unless the Member fails to provide necessary information.

If the Member does not provide necessary information, FCC will notify the Member of the specific information necessary to make a decision not later than 24 hours after FCC received the request. The Member may have up to 48 hours to provide the additional information. FCC will notify the Member of the decision regarding the claim no later than 48 hours after the earlier of (i) FCC's receipt of the additional information or (ii) the end of the time given the Member to provide the information.

The notice of a denial of an urgent care claim be oral. However, written notice must be provided to the Member no later than 3 days after the oral notice.

Procedures for Post-Service Claims

Post-service Claims will be processed by not later than 30 days after receipt of a properly completed Post-service Claim. This 30-day period may be extended by 15 days if FCC determines that the extension is necessary due to matters beyond the control of the Plan and properly notifies the Member of the extension prior to the expiration of the initial 30-day period. The extension notice shall include the circumstances requiring the extension and the expected date of the determination. If the extension is requested because of the need for additional information, FCC will notify the claimant of the needed information within the initial 30-day period and pend the claim until the information is received. The Member will be given 45 days after receipt of the notice to provide the requested information. Within 15 days of its receipt of the requested information, FCC shall notify the Member of its determination. If the Member fails to timely provide the requested information, FCC will notify the Member of its determination within 15 days after the expiration of the time to provide the information.

Concurrent Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your

request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

If your request is denied, the course of treatment shall continue while your internal appeal is pending.

NOTE: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a plan amendment or plan termination.

Form of Claim Notices

If a claim is denied by FCC, the denial notice (called an Explanation of Benefits in the case of Post-service Claims) will include (to the extent required by law):

- information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings);
- the specific reason(s) for the denial, including the denial code (and its meaning) and a description of any standard that was used in denying the claim;
- the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that the rule, guideline, protocol or other similar criterion that was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- references to the part of the Plan on which the denial is based, including plan limitations or exclusions;
- a description of any additional material or information necessary to decide your Claim and an explanation why such material or information is necessary;
- appropriate information as to the steps to be taken if you desire to Appeal the denial, including notice of applicable time limits and a statement regarding your right to bring suit following an adverse benefit determination on review;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- a description of the expedited review process for urgent care claims;
- a description of available external review processes, including information regarding how to initiate any appeal; and
- a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Appeals of Claims Determinations, Including Time Limits

If you have a question about benefits or a claims payment or denial, you should contact FCC Customer Service at the number listed on the back of your ID card. Most issues can be resolved by Customer Service and do not require a formal Appeal.

If you (or, a Provider) disagree with a decision made by the Plan or FCC about coverage, payment or a Preauthorization request, you may request an Appeal. Requests for Appeals must be made to FCC at the address below within 180 days after you receive notification of an adverse benefit determination.

Requests received after 180 days will not be considered. All requests should be made in writing; provided, however, that requests for Appeals of urgent care claims may be made orally.

Send Appeal requests to:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Attention: Appeals Coordinator

If an Appeal is requested, you shall have the following rights:

- to submit written comments, documents, records and other information relating to the claim for benefits and for the review to take into account all submitted materials regardless of whether such materials have already been submitted or considered during the initial benefit determination;
- upon request and free of charge, to have access to and copies of all documents, records and other information relevant to the Claim for benefits;
- to have a review that does not take into account the initial adverse benefit determination, and that is conducted by an appropriate named fiduciary who is neither the individual who made the initial benefit determination nor the subordinate of such individual;
- if the initial decision is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, a Provider who has the appropriate training and experience in the field of medicine will be consulted (and that the consulted Provider will not be an individual who was consulted during the initial benefit determination nor a subordinate of such individual);
- to obtain the identification of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination, without regard to whether the advice was relied upon in making the determination; and
- to receive, free of charge and in advance of a final internal appeal determination, any new or additional evidence or rationale relied upon or considered in making the determination and be given an opportunity to respond prior to the Claims Administrator making the internal appeal determination.

If your claim involves urgent care, you may submit a request (orally or in writing) to file an expedited appeal by telephone, you should call the phone number included in your denial. All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

Time Frames for Appeal Decisions and Notice

The decision regarding the Appeal of an urgent care claim shall be provided to the Member (and/or Providers, if applicable) as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the Appeal was received.

The decision on an Appeal of a Pre-service Claim (not for urgent care) or a Post-service Claim shall be provided in writing to the Member (and/or Providers, if applicable) within a reasonable period of time in light of the medical circumstances, but not later than 30 days after the Appeal was received.

For Appeals of Post-service Claims, decisions will be provided to the Member (and/or Providers, if applicable) within a reasonable period of time not to exceed 60 days after the Appeal was received.

If the decision on Appeal was adverse to the Member, the notification will include (to the extent required by law):

- information that enables you to identify the claim involved (including, if applicable, the date of service, the health care provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings);
- the specific reason(s) for the denial, including the denial code (and its meaning), and a description of any standard that was used in denying the claim;
- reference to the part of the Plan on which the decision is based;
- either the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that the rule, guideline, protocol or other similar criterion that was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- a statement of your right to bring an action after the exhaustion of the Plan's Appeal procedures;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- a description of available external review processes, including information regarding how to initiate any appeal; and
- the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Claims and Appeals for Prescription Drug Services

The following procedure applies to disputes about prescription drug benefits and coverage. For this purpose, the term "Prescription Drug Services" shall mean those outpatient prescription drug services or supplies provided as a covered benefit to Members as set forth in the Plan.

MedImpact will process any initial claim that is properly filed with MedImpact using the same procedure that applies to medical benefit claims (described above).

If a Member has a concern regarding an adverse benefit determination by MedImpact, the Member may call MedImpact's Customer Services team at 800-788-2949. Working with a MedImpact Customer Services Representative enables the Member to resolve most issues quickly and satisfactorily. If a Member feels that the issue has not been resolved after speaking with a MedImpact Customer Services Representative, a Member may initiate a verbal appeal by calling 800-788-2949 or may submit an appeal in writing to the following address:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131
Attn: Appeals Coordinator

An Appeal Form is available for the Member to complete and submit to MedImpact to initiate an appeal. When a Member calls MedImpact Customer Service to appeal a decision, the MedImpact Customer Service Representative will encourage the Member to complete and submit the Appeal Form. This will ensure the Member's issue is accurately documented.

Timelines for Member Appeals

Submission Timelines

If a Member decides to file an appeal, they must submit the appeal within one hundred eighty (180) days from the date of the non-approval notice. A physician or other authorized representative of the Member may file an appeal on behalf of a Member. MedImpact shall work with the Member, their authorized representative or physician to resolve the appeal.

If the Member is not satisfied with the determination of the appeal, they may file a second level appeal with MedImpact within ninety (90) calendar days of receipt of the first level appeal determination letter.

Acknowledgement Notification

MedImpact shall send the Member or the Member's authorized representative an acknowledgement letter confirming receipt of the appeal within five (5) calendar days of receipt unless it is an expedited appeal.

Standard Appeal Resolution Notification

MedImpact shall send a resolution letter to the Member or the Member's authorized representative and a copy to their physician within fifteen (15) calendar days for pre-service appeals and thirty (30) calendar days for post-service appeals. The resolution letter shall provide the specific determination, a clear and concise explanation of the reasons for the determination as well as any further appeal options available to the Member.

Expedited Appeal Resolution Notification

If an appeal involves an imminent and serious threat to the health of an Member- including, but not limited to severe pain, potential loss of life, limb, or major bodily function - MedImpact shall evaluate and resolve the appeal on an expedited basis and shall send the Member, or the Member's authorized representative, a resolution letter within twenty-four (24) hours from receipt of the first level appeal and forty-eight (48) hours from receipt of an associated second level appeal. Upon receipt of a request for an expedited appeal, MedImpact shall review the case to determine if it meets the criteria for an expedited appeal. If it does not meet those criteria, the appeal will be processed as a standard appeal within the applicable timelines (fifteen (15) calendar days for a pre-service appeal and thirty (30) calendar days for a post-service appeal). A post-service appeal shall not be handled as an expedited appeal.

Appeal Levels

Benefit Coverage/Administrative Standard and Expedited Appeal Levels

Upon receipt of an appeal, the MedImpact Appeals Coordinator shall document the case and determine whether it meets benefit guidelines. If it does not meet benefit guidelines, it shall be forwarded to the Administrative Review Committee ("ARC") for review and determination. The ARC is comprised of two (2) or more management level staff at MedImpact.

If the Appeals Coordinator determines the case meets benefit guidelines, the case shall be forwarded to the ARC to confirm that the case meets guidelines. If the ARC confirms the determination that the case meets guidelines, the appeal shall be granted. If the ARC disagrees with the determination, the case shall be upheld.

For standard appeals, if the Member is not satisfied with the appeal determination, MedImpact shall refer the Member back to FCC for assistance.

After the first level administrative appeal, the Member may contact FCC to initiate a second level administrative appeal. After exhausting all required levels of appeal, the Member shall have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act if they are not satisfied that the appeal has not been granted.

Medical Necessity Standard and Expedited Appeal Levels

Upon receipt of a first level medical necessity appeal, the MedImpact Appeals Coordinator shall document the case and determine whether it meets clinical guidelines. If it does not meet clinical guidelines, a MedImpact Pharmacist shall review the case and determine whether it meets clinical guidelines. If it does not meet clinical guidelines, the case is upheld. The Pharmacist may consult with MedImpact's Medical Director on complex cases.

If the Appeals Coordinator determines the case meets clinical guidelines, the case shall be forwarded to the Pharmacist to confirm that the case meets clinical guidelines. If the Pharmacist confirms the determination that the case meets clinical guidelines, the appeal shall be granted. If the Pharmacist disagrees with the determination, the case shall be upheld.

Upon receipt of a second level medical necessity appeal, the Appeals Coordinator documents any additional information that was submitted to support the appeal and determines whether the case meets clinical guidelines. If it does not meet clinical guidelines, a Pharmacist shall review the case and determine whether it meets clinical guidelines. If it does not meet clinical guidelines, the case shall be forwarded for review to the Medical Director. The pharmacist shall consult with the Medical Director on complex cases, and on all cases where the Pharmacist decides to grant an appeal. The Medical Director shall determine whether the case meets medical necessity criteria. If it does not meet medical necessity criteria, then MedImpact shall forward the case to an External Review Organization ("ERO") for evaluation.

If the Appeals Coordinator determines the case meets clinical guidelines, the case shall be forwarded to the Pharmacist to confirm that the case meets clinical guidelines. If the Pharmacist confirms the determination that the case meets clinical guidelines, the appeal shall be granted. If the Pharmacist disagrees with the determination that the case meets clinical guidelines, the case shall be forwarded to the Medical Director for review.

If the Medical Director determines that the case meets medical necessity criteria, the appeal shall be granted. If the Medical Director determines that the case does not meet medical necessity criteria, MedImpact shall forward the case to the ERO for evaluation.

After exhausting the required levels of appeal, a Member shall have the right to bring a civil action if the Member is not satisfied and the appeal has not been granted.

Foreign Language Assistance

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the Plan must provide the following language assistance:

- Oral language services in the applicable non-English language for claims, appeals and external review;
- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the Claims Administrator.

Claims and Appeals for Eligibility and other Non-Benefit Issues

Any claims for eligibility under the Plan or other non-benefit claims must be filed with the Plan Administrator. The Plan Administrator will respond to all such claims within the time frames that apply for benefit claims described above. All appeals of such claims must also be filed with the Plan Administrator within 180 days of the denial. The Plan Administrator will respond to all such appeals within the time frames that apply for appeals of denied benefit claims described above. However, external appeals are not available for eligibility claims and appeals.

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 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. This relates to claims for benefits under the Plan and to any other issue, matter, or dispute with respect to the Plan (including any Plan eligibility, interpretation or amendment issue). This exhaustion requirement shall apply even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a particular issue, matter or dispute. After you have filed your initial claim, the Plan Administrator will inform you of any specific claims procedures that will apply to your particular issue, matter or dispute, or it will apply the claims procedures above that apply to claims for benefits.

Limitations on Actions

You cannot bring legal action to recover any benefit (including benefits based on eligibility) under the Plan if you do not file a valid claim and seek timely review of a denial of that claim as provided above. Any claim or action that is filed in a court or other tribunal against or with respect to the Plan or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to health benefits, the claim or action must be brought within three years of the date the supply was furnished or the service was rendered.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim.

Any claim or action relating to the Plan (including claims for eligibility, benefits or other matters) must only be brought or filed in the United States District Court for the Eastern District of North Carolina.

Your Right To an External Review

Federal law gives you the right, in certain circumstances, to have an adverse benefit determination reviewed by an external independent review organization after you exhaust your rights under the internal claims and

appeals procedure. The following is a general description of the external review process. However, you should review your notice of adverse benefit determination carefully. The notice may contain updated information in the event the external appeals process changes.

Types of Eligible Determinations

The external review process under this Plan gives you the opportunity to receive review of a final internal adverse benefit determination (and in limited cases, an adverse benefit determination conducted pursuant to applicable law. Your request will be eligible for External Review only if it qualifies as one of the following:

- Medical Judgment Claims and Appeals: External review procedures apply to adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a benefit or experimental or investigational determinations).
- Rescissions of Coverage: External review procedures apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of a rescission.

External review procedures do not apply to any other adverse determination, including eligibility appeals.

External Review Request

You must submit the Request for External Review Form to FCC within 123 calendar days of the date you received the notice regarding your final internal adverse benefit determination (or adverse benefit determination, if applicable). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file for a voluntary external review, any applicable statute of limitations will be tolled while the external review is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However external review is voluntary, and you are not required to undertake it before pursuing legal action.

If you choose not to file for external review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Within 5 business days following the date the external review request is received, FCC will complete a preliminary review to determine whether you meet the requirements for an external review. To be eligible, you must meet the following requirements:

- You are or were covered under the Plan at the time the item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The denied appeal does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the internal appeal process; and
- You have provided all the information and forms required to process an external review.

If FCC does not adhere to the federal requirements for handling internal claims and appeals, you are deemed to have exhausted the internal claims and appeal process unless such failure was (1) de minimis; (2) nonprejudicial; (3) attributable to good cause or matters beyond the Plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the Plan's basis for asserting that it meets this standard.

Within 1 business day after completing the preliminary review, FCC will send you a written notice regarding your request. If the request is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information. If the request is not complete, the notice will describe the information or materials needed to make the request complete and you will have the later of the remaining time within the 4-month filing period or 48 hours following receipt of the notification to perfect your external review request.

Procedures After your Request is Approved

If your external review request is eligible, FCC will assign it to an Independent Review Organization (IRO) as required under federal law to conduct the external review. The assigned IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the assigned IRO within 10 business days following the date the notice is received additional information that the IRO must consider when conducting the external review. Any additional information received by the IRO from you will be shared FCC and the Plan. Upon receipt of this information by FCC and the Plan, FCC may reconsider its prior appeal decision and may reverse the prior denial of the internal appeal. If FCC reverses its decision and fully approves the internal appeal, then your claim will be paid accordingly, and the external review will be terminated.

If the external review is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for External Review. After a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

The IRO will deliver a notice of the final external review decision to you and FCC. Upon receipt of a notice of a final external review decision reversing the decision reached during the initial claim and appeal process, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review Requests

You may also make an expedited external review request to FCC at the time you receive (1) a denied urgent care internal claim if you have also filed at the same time an internal appeal; (2) a denied urgent care internal appeal; or (3) a denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility. Upon receipt of such a request, FCC will determine whether you are eligible for an expedited external review. If you are eligible, FCC will notify you immediately. The IRO will follow the procedures discussed above with respect to standard external reviews, provided that certain procedures will be provided on an expedited basis as follows:

- FCC must provide all documentation with respect to the denied internal claim or appeal immediately to the IRO; and
- Upon a determination that a request is eligible for External Review following preliminary review, FCC will assign an IRO. The IRO will provide notice of the external review decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, FCC and the Plan.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

☐ Made in error; or
☐ Made after the date the person should have been terminated under this Plan; or

☐ Made to any Covered Person or any party on a Covered Person's behalf where the employer determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

☐ File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
☐ Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
☐ Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
☐ Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
☐ Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

☐ Bills for services or treatment that have never been received; or
☐ Asks a Covered Person to sign a blank claim form; or
☐ Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-574-8556. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with the employer's Human Resource policy on family and medical leaves of absence, as if the employee was actively at work if the following conditions are met:

☐ Contribution is paid; and

☐ The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

☐ The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or

☐ The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes actively at work no new Waiting Period will apply.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all the following:

☐ The name and last known mailing address of the participant;

☐ The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

☐ A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and

☐ The period to which the order applies.

Please contact the Plan Administrator if You would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders

AFFORDABLE CARE ACT

It is the County of Moore’s policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance. The County of Moore will investigate fully any complaint that the County of Moore or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the County of Moore or the Plan has violated a provision of the Affordable Care Act, you are encouraged to share your complaint with the County of Moore by contacting the Plan Administrator. Please provide as much information as you can regarding your complaint to help the County of Moore with its investigation. The County of Moore will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain prior authorization. For information on prior authorization, contact Your Plan Administrator.

DISCRIMINATION IS AGAINST THE LAW

FirstCarolinaCare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FirstCarolinaCare Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- FirstCarolinaCare Insurance Company provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ○ Qualified sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - ○ Qualified interpreters
  - ○ Information written in other languages.

If you need these services, contact the Civil Rights Coordinator for FirstCarolinaCare Insurance Company. If you believe that FirstCarolinaCare Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

FCC Civil Rights Coordinator
FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Telephone: 1-855-367-8184
Fax number: 1-910-235-7854
Email: compliance@firstcarolinacare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, FCC's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHS Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

MULTI-LANGUAGE
INTERPRETER SERVICES

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-811-3298 (TTY 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-811-3298 (TTY 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-811-3298（TTY 711）。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-811-3298 (TTY 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-811-3298 (TTY 711)번으로 전화해 주십시오.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-811-3298 (ATS 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 711 TTY 1-800-811-3298.

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-811-3298 (TTY 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-811-3298 (телетайп: 711).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-811-3298 (TTY 711).

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-811-3298 (TTY 711).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-811-3298 (TTY 711)។

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-811-3298 (TTY 711).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-811-3298 (TTY 711) पर कॉल करें।

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ ຣ 1-800-811-3298 (TTY 711).

日本語 **(Japanese)**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-811-3298（TTY:711）まで、お電話にてご連絡ください。

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely, however the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Plan participants within 60 days following the adopted formal action that makes material changes to the Plan.

Your Rights if Plan is Amended or Terminated

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses incurred before You receive notice of termination.

You will be deemed to have received the written amendment or termination letter from the Plan Administrator three days after the letter is mailed to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

No Contract of Employment

This Plan is not intended to be and may not be construed as a contract of employment between You and the employer.

GLOSSARY OF TERMS

Accident: an unexpected, unforeseen and unintended event.

Activities Of Daily Living (ADL): the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Actual Charge: the non-discounted amount charged for the Covered Service by the Provider who furnishes the service.

Adaptive Behavior Treatment: behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs.

Alternate Facility: a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- ☐ Surgical services;
- ☐ Emergency services; or
- ☐ Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulance Transportation: professional ground or air Ambulance Transportation in an Emergency situation or when deemed Medically Necessary, which is:

- ☐ To the closest facility most able to provide the specialized treatment required; and
- ☐ The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Approved Clinical Trials: subject to additional requirements set forth in the "Covered Services" section relating to Approved Clinical Trials, a phase I, II, III or IV clinical trial that is (1) conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition (*i.e.*, likely to lead to death unless the course of the disease or condition is interrupted), and (2) is any one of the following:

- ☐ Federally-funded by one or more government agencies or entities designated in Section 2709(d)(1)(a) of the Public Health Service Act;
- ☐ Conducted under an investigational new drug application reviewed by the FDA; or
- ☐ Is a drug trial that is exempt from the investigational new drug application requirements.

Autism Spectrum Disorder: as defined, pursuant to N.C.G.S. § 58-3-192, by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. Autism Spectrum Disorder is not considered a mental illness.

Behavioral Health Provider: a licensed organization or professional providing diagnostic, therapeutic or psychological services for Mental Disorders and Substance Abuse Disorder.

Birthing Center: a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Close Relative: a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, step children and grandchildren.

Co-payment: the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment: medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses or Covered Services: any expense for health care services, items or supplies, or any portion thereof, which is incurred by a Covered Person and is a covered benefit under this Plan.

Covered Person: an Employee, Retired Employee or Dependent who is eligible for and enrolled under this Plan. A Covered Person may also be referred to as a "Member".

Custodial Care: nonmedical care given to a Covered Person to assist primarily with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible: the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible and the health care benefits to which it applies.

Dependent: see the Eligibility and Enrollment section of this SPD.

Developmental Disorder: characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Disorders generally do not have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental illness or other neurological symptoms.

Durable Medical Equipment: equipment which is designed for repeated use; is intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally, is not useful to a person in the absence of an Illness or Injury.

Emergency: a serious medical condition which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Enrollment Date:

- ☐ For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.
- ☐ For anyone who enrolls on a Special Enrollment date, the Enrollment Date is the first day of coverage.
- ☐ For Late Enrollees, the Enrollment Date is the first day of coverage.

Expense Incurred: the charge for a service, treatment, supply or facility. The expense is considered to be incurred on the date the service or treatment is given, the supply is received, or the facility is used.

Experimental, Investigational or Unproven: any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition except for Approved Clinical Trials. This includes, but is not limited to:

- ☐ Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- ☐ Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- ☐ Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy are not clearly established;
- ☐ Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

NOTE: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility: includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

Habilitative Services: are educational in scope and purpose and are rendered to develop, improve or accelerate functions that have never been present or are not present to the normal degree of a person of like age or sex.

Home Health Care: a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, **Nurse Services** are Intermittent home nursing care by professional registered nurses or by licensed practical nurses. **Intermittent** is occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Hospice Care: a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider: an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician, physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital:

- ☐ A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- ☐ Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- ☐ Has a staff of licensed Physicians available at all times; and
- ☐ It is accredited by a recognized Credentialing Entity approved by CMS and/or a state or federal agency and is Qualified to receive payments under the Medicare program; or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- ☐ It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- ☐ Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness: a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Infertility Treatment: services, tests, supplies, devices, or drugs which are intended to promote Fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to: Fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury: an act causing harm or damage to the body.

Inpatient: a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee: a person who enrolls under this Plan other than on:

- ☐ The earliest date on which coverage can become effective under the terms of this Plan; or
- ☐ A special Enrollment Date for the person as defined by HIPAA.

Learning Disability: a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian: the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Allowable Payment ("MAP"): the lesser of (1) the Provider's Actual Charge for the service or supply, or (2) the current provider reimbursement amount established by FCC.

Maximum Benefit: the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are incurred while the person is covered under the Plan.

Medically Necessary / Medical Necessity: health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, Mental Health Disorder, Substance Use Disorder, condition, disease or its symptoms, that are all the following as determined by us or our designee, within our sole discretion:

☐ In accordance with *Generally Accepted Standards of Medical Practice*; and
☐ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, Mental Health Disorder, Substance Abuse Disorder, disease or its symptoms; and
☐ Not mainly for Your convenience or that of Your doctor or other health care provider; and
☐ Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

FirstCarolinaCare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by FirstCarolinaCare and revised from time to time), are available to Covered Persons by calling FCC at the telephone number on Your ID card.

Medically Necessary Adaptive Behavioral Treatment: Adaptive Behavioral Treatment about which a licensed physician or licensed psychologist has determined that, for his or her patient that is a Member diagnosed with Autism Spectrum Disorder, meets all the following requirements:

- The intervention is necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of the Member with Autism Spectrum Disorder; and

- The treatment is ordered by a licensed physician or licensed psychologist and the treatment is to be provided or supervised by one of the following licensed professionals, so long as the services or supervision provided is commensurate with the licensed professional's training, experience, and scope of practice:

    - A licensed psychologist or psychological associate.
    - A licensed psychiatrist or developmental pediatrician.
    - A licensed speech and language pathologist.
    - A licensed occupational therapist.
    - A licensed clinical social worker.
    - A licensed professional counselor.
    - A licensed marriage and family therapist.

Mental Health Disorder: with respect to an illness or disorder as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, DSM-5, or a subsequent edition published by the American Psychiatric Association, a mental condition, other than Intellectual Disability alone: (1) when applied to an adult Member, which so lessens the capacity of the Member to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a Member who is a minor, so impairs the minor's capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment. Mental Health Disorder does not include an illness or disorder coded in the DSM-5 or subsequent edition as: an autism spectrum disorder; substance-related disorders, Sexual Dysfunctions not due to organic disease, or "V" codes.

Mentally Disabled: an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Ordinary Care: the degree of care, skill and diligence that a reasonable and prudent administrator would exercise in making a fair determination on a claim for benefits similar to the claim involved.

Orthotic Appliances: braces, splints and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally, is not useful to a person in the absence of an Illness or Injury.

Outpatient: medical care, treatment, services or supplies in a licensed facility in which a patient is not registered as a bed patient and room and board charges are not incurred.

Non-Participating Provider: a Provider who does not have a contract to provide Covered Services to Members.

Participating Pharmacy: a licensed entity, acting within the scope of their license in the state in which they dispense, that has entered into a written agreement with MedImpact Healthcare Systems and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Participating Provider: a Provider who has a contract to provide Covered Services to Members.

Participation: You and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after You pay the Plan year Deductible(s).

Physician: any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), a physician's assistant (PA), certified nurse practitioner, or a certified nurse midwife (CNM).

Placed for Adoption: the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan: the group health plan sponsored by the COUNTY OF MOORE.

Preventive / Routine Care: a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Provider: a person or place licensed to provide the type of health care services that may qualify as Covered Services.

Provider Directory: a list of the Participating Providers.

Prudent Layperson: a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified: licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery: surgical procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, Accident, or Illness. It is generally performed to achieve a normal appearance and may also be performed to improve or restore function.

Residential MHSA Treatment Center: a 24 hour professionally directed, licensed facility providing short-term transitional services designed to achieve predicted outcomes for stability and functionality for a Mental Health Disorder or in the provision of services for Substance Abuse Disorders. Residential MHSA Treatment Centers must comply with all the requirements of the Plan. These include:

- facility licensure with regard to the services that are being provided and any required certification from the state in which the facility operates.
- direct and personal oversight by a board-certified medical director in psychiatry or addictionology who provides onsite psychiatric evaluation and treatment with appropriate medication management services.
- the provision of evidence-based therapies guided by an assessment driven treatment plan with time limited and measurable goals.
- 24 hour, seven days a week nursing services;
- age appropriate additional services for minors; and
- an interdisciplinary staff consisting of social workers, nurses, counselors and behavior health specialists clinically trained to assess and treat the patient's condition with specialized training in behavior management techniques. Certified alcohol and drug counselors (CADC), licensed masters social workers (LMSW) or licensed professional counselors (LPC) can provide services at the facility if they are directly supervised by a clinically certified professional such as:
    - Psychiatrist
    - Psychologist PhD
    - Licensed clinical social worker (LCSW)
    - Clinical professional counselor
    - Licensed clinical professional counselor

Retired Employee: a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program and satisfies the Plan's eligibility requirements.

Substance Abuse Disorder: the misuse of alcohol or other substances, including Prescription Drugs that cause physical and/or psychological addiction.

Surgical Center: a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

☐ Provides drug services as needed for medical operations and procedures performed;

☐ Provides for the physical and emotional well-being of the patients;

☐ Provides Emergency services;

☐ Has organized administration structure and maintains statistical and medical records.

Telemedicine: the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Terminal Illness or Terminally Ill: a life expectancy of about six months.

Third Party Administrator (TPA): a service provider hired by the Plan to process medical claims, provide medical management or perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Geographical Area: a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period: the period of time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

You, Your: the Employee.