

Summary Plan Description For The County Health Plan

**North Carolina Association of
County Commissioners Group
Benefits Pool**

Traditional Dental Program

EFFECTIVE: July 1, 2010

NCACC Group Number 3327498

This document takes the place of any documents previously issued to you which described your benefits in the previous plan year.

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Important Information

This booklet provides a summary description of the medical benefits provided under the County Health Plan (the “Plan”). It does not describe or contain all Plan provisions or fully describe all rights and obligations. These benefits are provided through the Plan Administrator, North Carolina Association of County Commissioners (“NCACC”) Health Coverage Trust, d/b/a NCACC Group Benefits Pool (the “Pool”).

This is not an insured plan. The benefits described in this booklet or any rider attached hereto are self-insured through the Plan which is responsible for their payment. CIGNA provides dental claims administration services for the Plan, but does not insure the benefits described.

The Plan expects to be continued indefinitely, but reserves the right to terminate the Plan at any time and for any reason, without notice to Plan participants or to amend the Plan at any time for any reason without notice.

Explanation of Terms

You will find terms starting with capital letters throughout this document. To help you understand your benefits, most of these terms are defined in the Definitions section of this document.

How To File Your Claim

The prompt filing of any required claim form will result in faster payment of your dental claim.

You may get the required claim forms from your Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing dental claim office.

Dental Expenses

The first Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS:

- Be sure to use your Member ID and account number when you file the Plan's claim forms, or when you call your Plan's claim office.
- Your Member ID is the ID shown on your benefit identification card.
- Your account number is the 7-digit policy number shown on your benefit identification card.
- Prompt filing of any required claim forms results in faster payment of your claims.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to the Plan within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When the Plan receives the notice of claim, it will give to the claimant, or to the Employer for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not receive these claim forms within 15 days after the Plan receives notice of claim, he will be considered to meet the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to the Plan within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

The Employer, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Eligibility — Effective Date

Dental Benefits

Eligibility for Employee Coverage

Your employer may establish pre-enrollment criteria you must meet before you are eligible to enroll with the Plan. This may include satisfying a probationary or waiting period before your coverage begins.

You will become eligible for coverage on the day you satisfy any waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible Employee; and
- you normally work at least the number of hours per week as determined by your Employer to be eligible; or
- you are an eligible Retiree under the age of 65; or
- you are an eligible Retiree over the age of 65.

Eligibility for Dependent Coverage

For dependents to be covered under the Plan you must be covered and your dependent must be one of the following:

- Your lawful spouse.
- Domestic partner (varies by Employer).
- You or your spouse's unmarried dependent children age 19 or less, including newborn children from date of birth, stepchildren, adoptive children (from date of placement), foster children (from date of placement) and children for whom health benefit coverage is required via a court order.
- An unmarried dependent child age 19 who is either mentally and/or physically handicapped prior to the maximum dependent age. Proof of the child's condition and dependence must be submitted to the Plan within 31 days after the date the child ceases to qualify above. After that, the Plan may require yearly verification of the continuation of such condition.
- An unmarried dependent child who is a full-time student less than 26 years of age.

Waiting Period

All waiting periods are as defined by your Employer Group.

Classes of Eligible Employees

Classes of Eligible Employees are as defined by your Employer Group.

Employee Coverage

This plan is offered to you as an Employee of the Employer Group.

Late Entrant - Employee Waiting Period for Major Treatment

Late Entrant means your enrollment form is received by the Plan 30 days after your date of eligibility. Check with your Employer, some do not allow Late Entrants.

If you are a Late Entrant, and your plan allows late enrollments for dental, your coverage will become effective on the date your enrollment form is received. During the first 12 consecutive months of coverage, your dental benefits will be limited to "Preventive Services" on the list of procedures shown on the "Dental Services Schedule."

However, if you incur expenses for a Covered Dental Injury more than 90 days after you become a late applicant, benefits will be paid for that Covered Dental Injury subject to all other dental plan provisions.

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, the Plan recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by the Plan's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

The Plan will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, the Plan will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed \$250 - \$1,000).

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Missing Teeth Limitation

There is no payment for replacement of teeth that are missing when a person first becomes a Plan participant. After a person has been continuously covered for these benefits for 12 months, this limit will no longer apply. This limit will not apply to any person who is a member of the Initial Employee Group.

Covered Services

The following section lists covered dental services. If a service is not listed there is no payment unless the Summary of Benefits agrees to cover it. If the Summary of Benefits agrees to cover the service the level of payment will be consistent with similar services that provide the least expensive professionally satisfactory result.

Payment for a covered service is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in the Summary of Benefits.

The covered person is responsible for the balance of the provider's actual charge.

Class I Services - Diagnostic and Preventive Dental Services

Bitewing x-rays - Only 1 set in any Contract Year. Limited to a maximum of 4 films per set.

Clinical oral evaluation - Only 1 per 6-month period.

Prophylaxis (Cleaning) - Only 1 prophylaxis or periodontal maintenance procedure per 6-month period.

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 14 years old. Only 2 per person per Contract Year.

Topical application of sealant, per tooth, on an unrestored permanent bicuspid or molar tooth for a person less than 16 years old - Only 1 treatment per 60 months.

Space Maintainers - Limited to nonorthodontic treatment for prematurely removed or missing teeth for a person less than 16 years old.

Class II Services

Diagnostic Services

Complete mouth survey or panoramic x-rays - only 1 in any 5 Contract Year period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.

Individual periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any Contract Year.

Intraoral occlusal x-rays - Limited to 2 films in any Contract Year.

Fillings

Amalgam Restorations - Multiple restorations on one surface will be paid as a single filling. Benefits for replacement of an existing amalgam restoration are only payable if at least a Contract Year has passed since the existing amalgam was placed.

Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least a Contract Year has passed since the existing filling was placed.

Composite Resin Restorations - Restorations which involve either the mesial or distal surface are considered single surface restorations unless the incisal angle is also involved. Benefits for the replacement of an existing composite restoration are payable only if at least a Contract Year has passed since the existing filling was placed. Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.

Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Oral Surgery, Routine Extractions

Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.

Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Miscellaneous Services

Palliative (emergency) Treatment of Dental Pain - Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Minor Periodontal Procedures

Periodontal Scaling and Root Planing (if not related to periodontal surgery) - Per Quadrant - Limited to 1 time per quadrant of the mouth in any 3 Contract Year period. Not separately payable if performed on the same treatment plan as prophylaxis.

Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 months have passed since the completion of active periodontal surgery. Only 1 periodontal maintenance procedure or adult prophylaxis is payable in any 6-month period. This procedure includes an allowance for an exam and scaling and root planing.

Major Periodontal Surgery

Gingivectomy - Only one periodontal surgical procedure is covered per area of the mouth in any 3 Contract Year period.

Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any 3 Contract Year period.

Clinical Crown Lengthening - Hard Tissue - No limitation.

Mucogingival Surgery - Per Quadrant - only 1 periodontal surgical procedure is covered per area of the mouth in any 3 Contract Year period.

Osseous Surgery - only 1 periodontal surgical procedure is covered per area of the mouth in any 3 Contract Year period.

Bone Replacement Graft - First Site Quadrant.

Bone Replacement Graft - Each Additional Site in Quadrant.

Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any 3 Contract Year period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.

Pedicle Soft Tissue Graft - No limitation.

Free Soft Tissue Graft (including donor site surgery) - No limitation.

Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.

Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.

Denture Adjustments, Rebasing and Relining

Denture Adjustments - Only covered 1 time in any Contract Year, and only if performed more than one Contract Year after the insertion of the denture.

Relining Dentures, Rebasing Dentures - Limited to relining or rebasing done more than one Contract Year after the initial insertion, and then not more than one time in any 3 Contract Year period.

Tissue Conditioning - maxillary or mandibular - Payable only if at least one Contract Year has elapsed since the insertion of a full or partial denture and only once in any 3 Contract Year period.

Repairs To Crowns and Inlays

Recement Inlays - No limitation.

Recement Crowns - No limitation.

Repairs to Crowns - Limited to repairs performed more than one Contract Year after initial insertion.

Repairs To Dentures and Bridges

Repairs to Full and Partial Dentures - Limited to repairs performed more than one Contract Year after initial insertion.

Recement Fixed Partial Denture - Limited to repairs performed more than one Contract Year after initial insertion.

Fixed Partial Denture Repair, by Report - Limited to repairs performed more than one Contract Year after initial insertion.

Inlays, Onlays and Crowns

Inlays and Onlays - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 7 Contract Years have elapsed since the last placement.

Crowns - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 7 Contract Years have elapsed since the last placement. For persons under 16 years of age, benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns.

Benefits for crowns are based on the amount payable for nonprecious metal substrate.

Stainless Steel Crowns, Resin Crowns - Covered only when the tooth cannot be restored by filling and then only 1 time in a 3 Contract Year period. Limited to persons under the age of 16.

Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.

Class III Services

Diagnostic Procedures

Histopathologic Examinations - Payable only if the surgical biopsy is also covered under this plan.

Endodontic Procedures

Therapeutic Pulpotomy - Payable for deciduous teeth only.

Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy - Permanent Tooth - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy, Retreatment - by Report - Covered only if more than 2 Contract Years have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.

Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.

Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Hemisection - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

Oral Surgery - Surgical Extractions

Surgical Extraction – (except for the removal of impacted teeth) - Includes an allowance for local anesthesia and routine postoperative care

Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes an allowance for local anesthesia and routine postoperative care.

Other Oral Surgery

Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization) - Includes an allowance for local anesthesia and routine postoperative care.

Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes an allowance for local anesthesia and routine postoperative care.

Biopsy of Oral Tissue - Includes an allowance for local anesthesia and routine postoperative care.

Alveoloplasty - Includes an allowance for local anesthesia and routine postoperative care.

Vestibuloplasty - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions) - Includes an allowance for local anesthesia and routine postoperative care.

Removal of Odontogenic Cyst or Tumor - Includes an allowance for local anesthesia and routine postoperative care.

Removal of Exostosis - Maxilla or Mandible - Includes an allowance for local anesthesia and routine postoperative care.

Incision and Drainage - Includes an allowance for local anesthesia and routine postoperative care.

Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones - Autogenous or Nonautogenous, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Frenectomy (Frenulectomy, Frenotomy), Separate Procedure - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Hyperplastic Tissue - Per Arch - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Pericoronal Gingiva - Includes an allowance for local anesthesia and routine postoperative care.

Synthetic Graft - Mandible or Facial Bones, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Surgical Extraction of Impacted Teeth

Surgical Removal of Impacted Tooth - Soft Tissue - The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Partially Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Completely Bony - The benefit includes an allowance for local anesthesia and routine postoperative care.

Removal of Impacted Tooth; Completely Bony, with Unusual Surgical Complications - The benefit includes an allowance for local anesthesia and routine postoperative care.

Prosthetics

Full dentures — There are no additional benefits for personalized dentures or overdentures or associated procedures. The Plan will not pay for any denture until it is accepted by the patient. Limited to one time per arch per 7 Contract Years.

Partial dentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. The Plan will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 7 Contract Years unless there is a necessary extraction of an additional functioning natural tooth.

Add tooth to existing partial denture to replace newly extracted Functional Natural Tooth — Only if more than a Contract Year has elapsed since the insertion of the partial denture.

Complete and partial overdentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. The Plan will not pay for any denture until it is accepted by the patient. Limited to one partial denture per arch per 7 Contract Years unless there is a necessary extraction of an additional functioning natural tooth.

Post and core (in conjunction with a fixed bridge) — Covered only for endodontically treated teeth with total loss of tooth structure.

Prosthesis Over Implant

A prosthetic device, supported by an implant or implant abutment, is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 7 Contract Years old, is not serviceable and cannot be repaired.

Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers) - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 7 Contract Years old, is not serviceable, and cannot be repaired.

Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.

Cast Metal Retainer for Resin Bonded Fixed Bridge - Benefits will be considered for the initial replacement of a Necessary Functioning Natural Tooth extracted while the person was covered under the plan.

Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 7 Contract Years old, is not serviceable, and cannot be repaired.

Anesthesia and IV Sedation

General Anesthesia - Paid as a separate benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation - Paid as a separate benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Expenses Not Covered

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses.
- procedures which are not necessary and which do not have uniform professional endorsement.
- procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.

- procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint.
- the alteration or restoration of occlusion.
- the restoration of teeth which have been damaged by erosion, attrition or abrasion.
- bite registration or bite analysis.
- any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- core build-ups.
- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
 - (a) replacement occurs at least 7 Contract Years after the initial date of insertion of the current full or partial denture; or
 - (b) the partial denture is less than 7 Contract Years old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
 - (c) replacement occurs at least 7 Contract Years after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 7 Contract Years old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).

- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 7 Contract Years of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth.
- replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- replacement of lost or stolen appliances.
- replacement of teeth beyond the normal complement of 32.
- prescription drugs.
- any procedure, service, supply or appliance used primarily for the purpose of splinting.
- athletic mouth guards.
- myofunctional therapy.
- precision or semiprecision attachments.
- denture duplication.
- separate charges for acid etch.
- labial veneers (lamine).
- treatment of jaw fractures and orthognathic surgery.
- orthodontic treatment, except for the treatment of cleft lip and cleft palate.
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- charges for travel time; transportation costs; or professional advice given on the phone.
- procedures performed by a Dentist who is a member of the covered person's family (the covered person's family is limited to spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents), except in the case of a dental emergency and no other Dentist is available.
- temporary, transitional or interim dental services.
- any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 3 Contract Years as determined by the Plan.
- diagnostic casts, diagnostic models, or study models.
- any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of (\$100 - \$200) per Contract Year period);

- oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury or Sickness which is paid or payable under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no coverage;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of you Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for dental care or treatment:

- (1) Group coverage and/or group-type coverage, whether plan participant or self-plan participant, including closed panel coverage which neither can be purchased by the general public, nor is individually underwritten.
- (2) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

Closed Panel Plan

A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The plan that provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan

A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of

negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) The plan that covers you as an enrollee or an employee shall be the Primary Plan and the plan that covers you as a Dependent shall be the Secondary Plan;
- (2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- (3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - (b) then, the plan of the parent with custody of the child;

- (c) then, the plan of the spouse of the parent with custody of the child;
 - (d) then, the plan of the parent not having custody of the child, and
 - (e) finally, the plan of the spouse of the parent not having custody of the child.
- (4) The plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the plan that covers you as an Active Employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (6) If one of the plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. The Plan will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, the Plan will determine the following:

- (1) the Plan's obligation to provide services and supplies under this policy;
- (2) whether a benefit reserve has been recorded for you; and

- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the Plan will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If the Plan pays charges for benefits that should have been paid by the Primary Plan, or if the Plan pays charges in excess of those for which we are obligated to provide under the Policy, the Plan will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The Plan will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any coverage company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

The Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Right of Reimbursement

The Plan does not cover:

- 1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
- 2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government coverage, other than Medicaid, or similar type of coverage or coverage when coverage is provided on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described

in (1) and (2) above, the Plan shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Plan. You or your Dependent(s) or their representative shall execute such documents as may be required to secure the Plan's rights. The Plan shall be reimbursed the lesser of:

the amount actually paid by the Plan; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

Payment of Benefits

To Whom Payable

All Dental Benefits are payable to you. However, at the option of the Plan and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge the claim is based.

If you die while any of these benefits remain unpaid, the Plan may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release the Plan from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by the Plan when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by the Plan, the Plan will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Miscellaneous

If you are a Dental Plan member as well as a member of a health plan, you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a late entrant for Dependent Coverage.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health coverage policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian.

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you,

including a child who is placed with you for adoption, will be eligible for Dependent Coverage upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of coverage will also apply to an adopted child or a child placed with you for adoption.

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health coverage are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health coverage who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

COBRA Continuation Rights

What is COBRA Continuation Coverage

You and/or your Dependents are given the opportunity to continue health coverage when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless the Plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period or qualifying event.

When COBRA Continuation Is Available

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation

Only a "qualified beneficiary" may elect to continue dental coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have

elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the COBRA Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required contribution within 30 calendar days after the due date;
- cancellation of the Employer’s policy with the Plan;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable

maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

- fraud or misrepresentation of eligibility of any qualified beneficiary; or
- termination of the Plan.

Employer’s Notification Responsibilities

It is the Employer’s responsibility to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - (a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the COBRA Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
 - (b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the COBRA Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
 - (c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the COBRA Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable contribution. The notice will also include instructions for electing COBRA continuation coverage. You must notify the COBRA Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before

the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the Plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The contribution during the 11-month disability extension may not exceed 150% of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

- If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee contribution.
- If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee contribution.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family contribution attributable to the corresponding tier, e.g., Employee-child(ren), Family, Employee Plus One.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required contribution for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage

under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your

COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

When You Have A Concern

The Plan wants you to be completely satisfied with the care you receive. That is why we have established a process to address your concerns.

If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the Customer Service toll-free number on the back of your identification card and explain your concern. You can also express that concern in writing to: CIGNA, P.O. Box 5200, Scranton, PA 18505-5200.

The Plan will do its best to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, the Plan will get back to you as soon as possible, but in any case within 30 days.

Filing an Appeal

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

The Plan has a three step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call the toll-free number or write to the address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional who is licensed to practice medicine in North Carolina.

For level one appeals, the Plan will provide you, within three working days after receiving your request for review, with the name, address and telephone number of the Appeal Coordinator and information on how to submit written material. The Plan will respond in writing with a decision

within 15 calendar days after receiving an appeal for a required preservice or concurrent care coverage determination (decision). The Plan will respond within 30 calendar days after receiving an appeal for a postservice coverage determination. The Plan will remain liable for charges during a concurrent review until you are notified of the Plan's decision. You will receive a detailed response in writing for the coverage determination decision in clear terms describing the contractual basis or medical rationale.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. The Plan's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the Plan will respond orally with a decision within 72 hours, followed up in writing no later than the lesser of two working days or four calendar days after all necessary information is received.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration and who is licensed to practice medicine in North Carolina, as determined by the Plan's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals, the Plan will acknowledge in writing within 10 working days after receiving your request and schedule a Committee review. The acknowledgement will include the name, address, and telephone number of the Appeal Coordinator. The acknowledgement will also include a description of your appeal rights, including the right to: (a) request and receive all information relevant to the review; (b) attend the Committee meeting; (c) present your case to the Committee and submit supporting materials before and at the Committee meeting; (d) ask questions of any Committee member; and (e) be assisted by a representative of your choice such as a Physician, family member, Employer representative, or attorney. An attorney representing the Plan may also attend. For required preservice and concurrent care coverage determinations, the Committee review will be completed

within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request in writing or verbally that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. The Plan's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing within the lesser of two working days or four calendar days.

Level Three Appeal

The Plan strives to be responsive to you and encourages our Members Groups to discuss the benefits offered under the Plan and to present any thoughts and/or disputes concerning the coverage and the administration of the coverage. The Plan's Third Level Appeals policy and procedures will be utilized to provide the Member Group a forum to address the decision or action taken by the Plan. In the event of a third level appeal, we will discuss the issue(s) with a Member Group and investigate and research the issue(s) in a effort to resolve the matter, while providing the Member Group a full and complete explanation of our decision. In order for a Plan Participant to have their appeal heard at the Third Level, the Member Group under which the Plan Participant is employed must support and submit documentation to the Plan on your behalf. You may not submit an Appeal to the Plan directly.

The Appeals process relates to disputes regarding a decision or action taken by the Plan concerning coverage through, or the administration of, the Plan and an appeal may be filed by a Member Group participating in the Plan. A Member Group may file an appeal on behalf of an Employee/Plan Participant; however, decisions made by the Claims Administrator for the Plan (CIGNA), is required at both first and second level reviews prior to addressing the appeal via this third level appeals process.

An third level appeal will address the following issues: contribution or claim funding, disputes concerning the scope of coverage and interpretation of coverage documents or governing documents; disputes concerning underwriting procedures including rates, debits and credits, program recommendations and implementation, disputes concerning the administration of the Plan; disputes concerning the validity of a claim, the settlement of a claim, decisions

concerning the litigation of a claim and the decision to appeal or not to appeal the matter; and other matters in the discretion of the Standing Appeals Committee that should be addressed in the best of interest of the Plan.

An appeal shall be filed within thirty (30) days of a decision made by the Plan's Claims Administrator. The thirty (30) day period will commence when the Member Group, or prospective Member Group, knew or should have known of the decision or action.

The process for the appeal should commence with the submission of an appeal form. You may call the NCACC toll-free at (866) 237-9163 to get an appeal form sent to you. Once we receive your appeal, the Review Committee will review it to determine the basis of the appeal and the remedy sought. The Committee will consider the appeal, the Plan's governing documents, coverage documents, other information provided to the Plan by its service partners, applicable statutory provisions (state/federal), case law and prior precedence. The Committee will determine if it is in the best interest of the Plan to grant the appellants' request, or if an alternative remedy is appropriate. If necessary, the Review Committee will communicate with NCACC Staff and service partners to discuss the basis of the Appeal and to resolve the same. Subsequent to the referenced review process by the Committee, the Plan will advise you in writing with regard to the Committee's findings and results of the appeal review. If you decide that your appeal has still not been resolved to your satisfaction, you may within ten (10) days, request that the standing appeals committee review the matter. The request should be submitted, in writing, to the Assistant Executive Director, Risk Management Services of the NCACC. In response to your request, the Standing Appeals Committee may convene to review the appeal within a reasonable time period. The committee will review your appeal and determine if it is in the best interest of the Plan to grant your request or if an alternative remedy is appropriate. Lastly, within thirty (30) days of the written notification being sent to you, the Standing Appeals Committees' decision may be appealed to the NCACC Board of Trustees.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the Plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that

was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Definitions

Active Service

You will be considered in Active Service:

on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Chewing Injury

Chewing Injury means an injury which occurs during the act of chewing or biting. The injury may be caused by biting on a foreign object not expected to be a normal constituent of food; by parafunctional (i.e., abnormal) habits such as chewing on eyeglass frames or pencils; or biting down on a suddenly dislodged or loose dental prosthesis.

COBRA Administrator

The COBRA Administrator is the party chosen by your Employer to provide notification, collect contributions, and process elections and terminations of COBRA coverage.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that the plan participant is required to pay under the Plan.

Covered Dental Injury

Covered Dental Injury means all damage to a covered person's mouth due to an accident caused by an External Force, and all complications arising from that damage. The term Covered Dental Injury does not include damage to teeth, dental appliances or prosthetic devices which results from chewing or biting food or other substances. A Chewing Injury is not a Covered Dental Injury.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent

Dependents are:

- your lawful spouse;
- domestic partner (varies by Employer);
- any unmarried child of yours who is
 - less than 19 years of age; or
 - age 19 and determined to be mentally and/or physically handicapped prior to the maximum dependent age. Proof of the child's condition and dependence must be submitted to the Plan within 31 days after the date the child ceases to qualify above. After that, the Plan may require proof of the continuation of such condition.

A child includes an adopted child or foster child including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild who lives with you. Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time, seasonal, substitute or temporary or who normally work less hours per week than required as determined by your Employer.

Employer

The term Employer means the County that is the sponsor of the Plan.

External Force

External Force means any sudden, unexpected impact from outside the oral cavity.

Functioning Natural Tooth

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the covered person's other arch by another natural tooth or prosthetic (i.e., artificial) replacement.

Handicapping Malocclusion

Handicapping Malocclusion means a malocclusion which severely interferes with the ability of a person to chew food, as determined by the Plan.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

The Plan uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The percentile used to determine the Maximum Reimbursable Charge is listed in the Summary of Benefits.

Additional information about the Maximum Reimbursable Charge is available upon request.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary and/or Dentally Necessary

Services provided by a Dentist or Physician as determined by the Plan are Medically/Dentally Necessary if they are:

- (1) required for the diagnosis and/or treatment of the particular dental condition or disease; and
- (2) consistent with the symptom or diagnosis and treatment of

the dental condition or disease; and

- (3) commonly and usually noted throughout the medical/dental field as proper to treat the diagnosed dental condition or disease; and
- (4) the most fitting level or service which can safely be given to you or your Dependent.

A: (1) diagnosis, (2) treatment and (3) service with respect to a dental condition or disease, is not Medically/Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Natural Tooth

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development for the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

Necessary

Necessary means a procedure, service or supply which is required by, and appropriate for, treatment of the covered person's dental condition according to broadly accepted standards of care, as determined by the Plan in consultation with our dental consultant.

Orthodontic Treatment

Orthodontic Treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a handicapping malocclusion of the mouth.



CIGNA HealthCare

**NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS GROUP BENEFITS POOL
NOTICE OF PRIVACY PRACTICES**

*****SUMMARY*****

This Notice is being provided to you by the North Carolina Association of County Commissioners Health Coverage Trust, d/b/a NCACC Group Benefits Pool (the Pool). A federal law, known as the HIPAA Privacy Rule, requires that we explain how we may use and release health information about you. This Summary is to give you an overview of our Privacy Notice that follows this Summary. For more information, you may read the full Notice. You may also contact our Privacy Official.

Certain components of the Pool are covered by the HIPAA Privacy Rule but other components are not. The only components of the Pool that are covered by the HIPAA Privacy Rule are the medical and dental benefits. This Notice only applies to those components of the Pool.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

We may use and disclose protected health information (“PHI”) to you, to your personal representative, for payment, for certain business activities called “health care operations,” and for the treatment purposes of health care providers. Subject to conditions and limitations that may apply, we may make these uses and disclosures without your consent or authorization. Under certain circumstances, we may disclose PHI to individuals involved in your care or payment for your care.

Some examples of how we may also use and disclose PHI without your authorization include a use or disclosure: to report abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for public health reasons; for health oversight activities; for lawsuits and other legal proceedings; for research; for specialized government functions such as military or national security purposes; and for workers’ compensation.

YOUR RIGHTS

You have the following rights as described in our Notice:

- Right to ask us if we will agree to more restrictions on our use or disclosure of PHI about you;
- Right to receive confidential communications from us;
- Right to inspect and copy PHI about you;
- Right to ask us to amend PHI about you; and
- Right to request a report about certain types of disclosures (if any) of PHI about you.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services.

FOR MORE INFORMATION:

If you have any questions about this Notice, you may contact our Privacy Official at the following mailing address or phone number:

Privacy Official
215 N. Dawson Street
Raleigh, NC 27602
Phone: (919) 716-0032

*****End of Summary*****

**NCACC GROUP BENEFITS POOL
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Original Effective Date: April 14, 2003

This Notice is being provided to you by the North Carolina Association of County Commissioners Health Coverage Trust, d/b/a NCACC Group Benefits Pool (the Pool). A federal regulation, known as the HIPAA Privacy Rule, requires that health plans provide detailed notice in writing of their privacy practices. This Notice is long. The HIPAA Privacy Rule requires us to provide you with a lot of information in this Notice.

Certain components of the Pool are covered by the HIPAA Privacy Rule but other components are not. The only components of the Pool that are covered by the HIPAA Privacy Rule are the medical and dental benefits. This Notice only applies to those components of the Pool.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about health plan participants. The HIPAA Privacy Rule requires that we protect the privacy of health information about you that can be used to identify you. This information is called “protected health information” or “PHI.” In addition to the protections under HIPAA, North Carolina law and other Federal law may provide additional protections of health information about you in some circumstances. This Notice describes your rights as a health plan participant and our obligations regarding the use and disclosure of PHI under HIPAA and other applicable laws. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

As permitted by the HIPAA Privacy Rule, we reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will provide you with the new Notice by mail within 60 days of the change.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

A. Uses and Disclosures to You, to Your Personal Representative, and for Treatment, Payment, and Health Care Operations

Subject to the other laws that we discuss later in this Notice, the following categories describe the different ways we may use and disclose PHI to you, to your personal representative, and for treatment, payment, or health care operations without your authorization. The examples included in each category do not list every type of use or disclosure that may fall within that category.

Disclosures to You: We may disclose to you PHI about you.

Disclosures to Your Personal Representative: We may make disclosures to your personal representative. Your personal representative is generally someone who has the authority under state law to act on your behalf in making decisions related to your health care. If you are deceased, your personal representative is the person who has the authority under state law to act on your behalf or on behalf of your estate.

Treatment: We may use and disclose PHI about you to assist your health care provider in coordinating or managing your health care and related services.

Payment: We may use or disclose PHI to pay or deny your claims, to collect your premiums, or for the payment activities of your health care providers or your other insurer(s). We may use and disclose PHI to tell you whether a particular type of health care service is covered under your policy.

Health Care Operations: We may use and disclose PHI in performing business activities that are called health care operations. Health care operations include doing things that allow us to improve our operations. Health care operations also include things that we do to reduce costs. For example, we may use and disclose PHI about you in health care operations to do the following things:

- Review and improve the quality, efficiency, and cost of our operations.
- Improve our methods of payment, coverage policies, or customer service.
- Set premiums or perform certain other activities related to the business of health coverage.
- Improve health care and lower costs for groups of people who have similar health problems.
- Identify groups of people with similar health problems to give them information, for example, about treatment alternatives and educational classes. We may also use this information to help manage and coordinate the care for these groups of people.
- Provide training programs for non-health care professionals.
- Cooperate with various people who review our activities. For example, PHI may be seen by accountants, lawyers, and others who assist us in complying with the law and managing our business.
- Resolve any complaints that you have.
- Assist us in making plans for the Plan's future operations.
- Resolve grievances within our organization.
- Do business planning and development, such as cost-management analyses.
- Do business management and general administrative activities of the Plan, including management of our activities related to complying with the HIPAA Privacy Rule and other legal requirements.
- Create "de-identified" information that is not identifiable to any individual, and disclose PHI to a business associate for the purpose of creating de-identified information, regardless of whether we will use the de-identified information.
- Create a "limited data set" of information that does not contain information directly identifying a participant. Our ability to disclose this information to others under limited conditions is discussed later in this Notice.

If a health care provider, company, or other health plan that is required to comply with the HIPAA Privacy Rule also has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company. For example, we may use and disclose PHI to do the following things: review and improve the quality, efficiency, and cost of services provided to you; provide training programs for non-health care professionals; cooperate with outside organizations that evaluate health plans; and assist with the licensing, certification, or credentialing activities of that health care provider, company, or other health plan.

B. Other Uses and Disclosures We Can Make Without Your Written Authorization to Which You Have the Opportunity to Agree or Object

We may use and disclose PHI about you in some situations if you do not object after you have been provided an opportunity to do so. However, when you are not present or when we cannot practicably provide you with the opportunity to agree or object because of your incapacity or because of an emergency circumstance, we may, in the exercise of professional judgment, determine whether the disclosure is in your best interests.

Individuals Involved in Your Care or Payment for Your Care: We may disclose to your family member, close friend, or any other person identified by you, PHI about you that is directly relevant to that person's involvement in your care or payment for your care. We may also use and disclose PHI necessary to notify these persons of your location, general condition, or death.

Disaster Relief: We also may share PHI about you with disaster relief agencies (for example, the Red Cross) for disaster relief purposes.

C. Other Uses and Disclosures We Can Make Without Your Written Authorization or Opportunity to Agree or Object

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditions that may apply.

Required By Law: We may use and disclose PHI as required by federal, state, or local law to the extent that the use or disclosure complies with the law and is limited to the requirements of the law.

Incidental Disclosures: We may use and disclose PHI when such uses and disclosures are incidental to uses and disclosures that are permitted or required by HIPAA, so long as we implement safeguards to avoid such disclosures, and we limit the scope of PHI exposed by these incidental disclosures.

Health Plan Sponsor: We may disclose PHI to the employer or other organization that sponsors your group health plan. Please see your employer or your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in conducting plan administration. We may also disclose summary information about enrollees in your group health plan to the plan sponsor to use to obtain premium bids for health coverage offered through your group health plan or to decide whether to modify, amend, or terminate your group health plan.

Public Health Activities: We may use and disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

- To prevent or control disease, injury, or disability;
- To report disease, injury, birth, or death;
- To report child abuse or neglect;
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- To locate and notify persons of recalls of products they may be using; or
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a participant has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency;
- To alert law enforcement of a death that we suspect was the result of criminal conduct;
- Required by law;
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About a crime or suspected crime committed at our office; or
- In response to a medical emergency not occurring at the office, if necessary to report a crime, including the nature of the crime, the location of the crime or the victim, and the identity of the person who committed the crime.

We may not, however, disclose the fact that you have sought treatment for drug dependence to law enforcement.

To Avert a Serious Threat to Health or Safety: We may use and disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

Specialized Government Functions: Under certain conditions, we may disclose PHI:

- For certain military and veteran activities, including determination of eligibility for veterans' benefits and where deemed necessary by military command authorities;
- For national security and intelligence activities;
- To help provide protective services for the President of the United States and others;
- For the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations or for general safety and health related to correctional facilities.

Workers' Compensation: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Organized Health Care Arrangements: We may disclose PHI about you for the health care operations of organized health care arrangements in which the Plan may participate. Organized health care arrangements in which the Plan may participate include the organized health care arrangement between the Plan and a group health plan of a participating local government with respect to individuals who are or who have been participants in the Plan.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you, or someone who has the legal right to act for you, when you request access to PHI or request an accounting of certain disclosures of PHI about you (these requests are described in Section III of this Notice).

Limited Data Set Disclosures: We may use or disclose a limited data set (PHI that has certain identifying information removed) for the purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

Business Associates: We may share PHI with other parties called "business associates" who help us with providing services to you. We are required to sign contracts with these business associates that require them to protect PHI.

Other Purposes: Although unlikely to apply to most participants of the Plan, the Privacy Rule permits covered health plans, in some cases, to disclose PHI to coroners, medical examiners, funeral directors, and organ and tissue donation organizations, and for research.

D. Other Uses and Disclosures of Protected Health Information Require Your Authorization

All other uses and disclosures of PHI about you will be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may later revoke your authorization at any time, except to the extent we have taken action based on the authorization.

E. Additional Protections of Protected Health Information That Are Provided Under North Carolina Law or Other Law

In the event that North Carolina law requires us to give more protection to PHI about you than required by HIPAA, we will provide that additional protection. Some areas where North Carolina law may provide more protection include information related to communicable diseases, such as HIV and AIDS, as well as information related to treatment for mental health and drug and alcohol abuse.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under the HIPAA Privacy Rule, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use or disclose for treatment, payment and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the Privacy Rule. *We are not required to agree to your request.* If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency.

To request restrictions, you must make your request in writing to our Privacy Official. In your request, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, limiting use to this office, restricting disclosures made to persons outside this office, or both); and (3) to whom you want those restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location if you tell us that the disclosure of all or part of PHI that relates to you could endanger you. For example, you may request that we contact you at home, rather than at work. You must make your request in writing. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate only your *reasonable* requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes medical and billing records but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI, please contact our Privacy Official. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for the Plan. To make this type of request, you must submit your request in writing to our Privacy Official. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an “accounting” of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to 6 years, but these *do not include* disclosures made: for treatment, payment, and health care operations; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative; for certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes); as incidental disclosures that occur as a result of otherwise permitted disclosures; as part of a limited data set of information that does not directly identify you; and disclosures made before April 14, 2003.

If you wish to make such a request, please contact our Privacy Official identified on the last page of this Notice. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Official listed in this Notice.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, please contact our Privacy Official at the mailing address or phone number listed below. We will not retaliate or take action against you for filing a complaint.

V. QUESTIONS

If you have any questions about this Notice, please contact our Privacy Official at the mailing address or phone number listed below.

VI. PRIVACY OFFICIAL CONTACT INFORMATION

You may contact our Privacy Official at the following mailing address or phone number:

Privacy Official:
215 N. Dawson Street
Raleigh, NC 27603
Phone: (919) 716-0032

This Notice is effective on April 14, 2003.