

Summary Plan Description For The County Health Plan

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

OPEN ACCESS PLUS MEDICAL BENEFITS (PPO)
CVS/CAREMARK PHARMACY

EFFECTIVE DATE: July 1, 2010

NCACC Group Number 3327498

This document and the accompanying Summary of Benefits take the place of any documents previously issued to you which described your benefits under this Plan.

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IMPORTANT INFORMATION—PLEASE READ CAREFULLY

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 medical claims administration services for the Plan, but does not insure the benefits described. Additionally, CVS/Caremark provides pharmacy benefit management to the Plan, but does not insure the pharmacy 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.

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Search for Participating Providers on the website at www.nccountyhealthplan.org. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free numbers shown on the back of your ID card.

Contacting Customer Service

Toll-free customer service lines allow you to talk to health care professionals during normal business hours, Monday through Friday, simply by calling the toll-free numbers shown on the back of your ID card.

The customer service representative can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may call the toll-free numbers for assistance. If you or your Dependents need medical care while away from home, you have access to a national network of Participating Providers. Call the toll-free customer service lines for the names of Participating Providers in other network areas. It is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Plan.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a

clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Case Management does not apply to your pharmacy benefits.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

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.

Opportunity to Select a Primary Care Physician

With the County Health Plan, you are not required to choose a Primary Care Physician.

Important Notices

Important Notice

This is to advise you that the Plan will, upon request, provide you with the following for the current and prior Plan year:

- evidence of coverage, coverage policy or benefits summary of any other type of health plan;
- an explanation of the utilization review criteria;
- treatment and protocol for specified conditions of a prospective individual, in writing, if so requested;
- written reasons for a denial of a recommended or authorized treatment;
- an explanation of the utilization review criteria or treatment protocol upon which the denial was based;
- the Plan's Primary/Preferred Drug List or prior approval requirements for obtaining prescription drugs; and
- the Plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental.

How To File Your Claim

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

Notice of Claim

Written notice of claim must be given to the Plan within 18 months 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.

Note: For Member Groups no longer participating in the Plan, the Notice of Claim provision will be subject to the claims

payment agreement between the terminating Member Group and the Plan.

Depending on your Plan benefits, file your claim forms as described below.

Hospital Confinement

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to the Plan.

Doctor's Bills and Other Medical Expenses

The first Medical 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.

Prescription Drugs

If you use an out of network pharmacy you must submit a paper claim and original receipt to CVS Caremark within 545 days from date of fill. The Drug Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bill **must** be sent with the claim form. If you have additional bills after the first prescription is filled, file them periodically for reimbursement. More often your participating pharmacy will file these claims electronically for you so you do not have to file them yourself.

Claims forms can be downloaded from www.CVS-Caremark.com, or obtained by calling the CVS Caremark number on the back of your benefit card. Please send completed claim form and all original prescription receipts to:

CVS Caremark, Inc.
Attn: Claims Department
P.O. Box 686005
San Antonio, TX 78268-6005

Claim Reminders

- Be sure to use your member id and account number when you file claim forms, or when you call your 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.

Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 25% for Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under the Plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which the Plan has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Prior Authorization/Pre-Authorized-In-Network

The term Prior Authorization means the approval, prior to services being rendered, that you receive from the Review Organization in order for certain services and benefits to be covered under this policy.

Nonemergency services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except when admitted due to pregnancy;
- inpatient services at any Other Participating Health Care Facility;
- residential treatment;
- nonemergency ambulance; or
- transplant services.

Continuity of Care

If your Participating Provider leaves the network, you may be able to continue receiving care through him or her for a temporary period if you have a special condition. This option may also be available to you as a newly-enrolled covered individual whose Employer has changed health benefit plans.

Transitional Period

You must notify the Plan within 30 days of the date notice is sent to you and if you elect to continue receiving treatment by the provider, you are subject to the following conditions:

- Ongoing Special Condition. The transitional period will extend up to 90 days for the following:
- In the case of an acute illness, which is a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
- In the case of chronic illness, disease or condition that is life-threatening, degenerative, or disabling and requires medical care or treatment over a prolonged period of time.
- Scheduled Surgery, Organ Transplantation, or Inpatient Care. The transitional period will extend through the date of the discharge of the covered individual and through post-discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of the discharge. This period will also apply to a covered individual who has been placed on an established waiting list for a transplant.
- Pregnancy. The transitional period will extend through the provision of 60 days of postpartum care for a covered individual who has entered the second trimester of pregnancy on the date notice is sent to the covered individual or the effective date of a newly-eligible

covered individual, and the provider was treating the pregnancy before the date of the notice.

- Terminal Illness. If you have a life expectancy of 6 months or less, the transitional period will extend for the remainder of your life with respect to care directly related to the treatment of the terminal illness. The provider must have been treating the terminal illness before the provider's date of termination or the effective date of the newly-eligible covered individual.
- If the provider is a Participating Provider and his or her contract with the Plan is terminated, the provider must agree to accept the rates applicable before the start of the transitional period as payment in full.
- If you are a newly-eligible covered individual undergoing treatment from a provider under a previous health benefit plan who is a non-Participating Provider with the Plan, the provider must agree to accept the Plan's current prevailing base fee schedule plus the applicable Copayment as reimbursement in full from the Plan for all Covered Expenses.
- The provider must agree to comply with the Plan's quality assurance programs and adhere to any established policies and procedures for Participating Providers, including procedures regarding referrals and obtaining prior authorization (if any), providing services in accordance with the treatment plan (if any), approved by the Plan.

The Plan is not required to provide coverage of benefits that would not have been covered if the provider remained a Participating Provider or, in the case of a newly-eligible covered individual, require coverage of benefits not provided by the Plan.

A transitional period is not available to you if the Plan has terminated a Participating Provider's contract for reasons relating to quality of care or fraud. You are not permitted to appeal the Plan's decision not to offer a transitional period under these circumstances.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by the Plan. **Any applicable Copayments, Deductibles or limits are shown in the Summary of Benefits.**

Covered Expenses include:

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except

that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in Summary of Benefits.

- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in Summary of Benefits.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made for Routine Preventive Care from age 2 including immunizations. Routine Preventive Care means

health care assessments, wellness visits and any related services.

- charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child's life, including immunizations.
- charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be otherwise approved by the FDA and recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the three established reference compendia: (i) the American Medical Association Drug Evaluations; (ii) the American Hospital Formulary Service Drug Information; or (iii) the United States Pharmacopeia Drug Information.
- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: (a) Dependent children below age 9; (b) covered persons with serious mental or physical conditions; or (c) covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
- charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.
- charges for newborn hearing screening when ordered by a Physician to determine the presence of permanent hearing loss.
- charges for colorectal cancer examinations and laboratory tests for cancer for nonsymptomatic covered individual who is: (a) at least 50 years of age, or (b) less than 50 years of age but at high risk for colorectal cancer according to the most recently published guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.
- charges for mammograms, beginning at age 40 will be covered per female member per calendar year, along with a Physician's interpretation of the laboratory results. Reimbursement for laboratory fees shall only be made if the laboratory meets the mammography accreditation standards established by the North Carolina Medical Care Commission of the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography. Mammograms may be done more

frequently if recommended by a Physician because the woman has a personal history of breast cancer or biopsy-proven benign breast disease; a female family member has had breast cancer or the woman has not given birth before the age of 30.

Genetic Testing

Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- you have symptoms or signs of a genetically-linked inheritable disease.
- it has been determined that you are at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidenced based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per Contract Year for both pre-and postgenetic testing.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Providers for care of or related to the female reproductive system and breasts, and for annual screening, counseling and immunizations for disorders and diseases in accordance with the most current recommendations of the American College of Obstetricians and Gynecologists. Gynecological services include coverage for cervical cancer screening and surveillance tests for ovarian cancer.

Cervical cancer screening includes examinations and laboratory tests for the early detection of cervical cancer. Examinations and laboratory tests means conventional Pap smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis have been approved by the United States Food and Drug administration. Surveillance tests are for women age 25 and older at risk for ovarian cancer. "At risk for ovarian cancer" means either:

- having a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-

degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or

- testing positive for a hereditary ovarian cancer syndrome.
- “Surveillance tests” mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination.

Clinical Trials

Your health benefit plan provides benefits for participation in clinical trials phase II, III and IV. Coverage is provided only for Medically Necessary costs of health care services associated with the trials, and only to the extent that such costs have not been or are not funded by other resources. The trial must involve the treatment of life-threatening medical condition with services that are medically indicated and preferable to noninvestigational treatment alternatives and have clinical and preclinical data that shows the trial will likely be more effective for you than available noninvestigational alternatives. In addition the trial must meet the following requirements:

- must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
- must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
- must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients.

Clinical Trial Costs

If a claim contains charges related to services required and those charges cannot be separated from costs related to services for which coverage is not required, the health benefit plan may deny the claim.

Clinical trial costs not required to be covered by a health benefit plan include:

- nonhealth care services, those services provided solely to satisfy data collections and analysis needs;
- investigation drugs and devices, and services not provided for the direct clinical management of the patient.
- charges for prescription contraceptives and devices approved by the U.S. Food and Drug Administration. Benefits will also include the insertion and/or removal of a prescription contraceptive device and any Medically

Necessary exam associated with use of the prescription contraceptive device.

Insulin and Noninsulin-Dependent Diabetics

The following benefits will apply to insulin and noninsulin-Dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for blood glucose monitors and blood glucose monitors for the legally blind, insulin pumps and appurtenances thereto, and insulin infusion devices.
- charges for podiatric orthotics that are casted and molded; excluding diabetic shoes.
- Supplies for insulin pump, insulin infusion set, syringes, pre-filled cartridges for the blind; glucose testing strips, lancets, including consumable supplies for the insulin pump, such as tubing, catheters, etc.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
 - Medically Necessary visits when diabetes is diagnosed;
 - Visits when re-education or refresher training is prescribed by a Physician; and medical nutrition therapy related to diabetes management; and
 - Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management.

If a member has an insulin pump that requires consumable medical supplies (such as tubing, catheters, etc.) this is covered 100% under medical no deductible, if in-network. The ordering Physician should contact Edgepark’s Surgical at 800.321.0591.

All durable medical equipment must be ordered through National DME vendor APRIA HealthCare at 800.901.3566. The ordering Physician must contact APRIA HealthCare to order these supplies for the member and they will be shipped out to him/her. Medically necessary durable medical equipment is covered under the DME benefit in the NCACC summary plan document.

Bone Mass Measurement

Bone Mass Measurement (BMM) means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment.

Charges for a qualified person will be covered for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed Medically

Necessary. Conditions that would be considered Medically Necessary include, but are not limited to: (1) monitoring covered individuals on long-term glucocorticoid therapy of more than 3 months; or (2) a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

A Qualified Person for BMM means one who:

- is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
- is experiencing radiographic osteopenia anywhere in the skeleton;
- is receiving long-term glucocorticoid (steroid) therapy;
- is having primary hyperparathyroidism;
- is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
- has a history of low-trauma fractures;
- has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.

Nutritional Evaluation

Nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

Internal Prosthetic/Medical Appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Home Health Services

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if the Plan has determined that the home is a medically appropriate setting. If you are a minor or an adult who is Dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals.

A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in Summary of Benefits, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in the Summary of Benefits.

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in Summary of Benefits;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of an Other Health Care Professional;
 - physical, occupational and speech therapy;
 - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment services are exchanged with Inpatient Mental Health services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Inpatient Substance Abuse Services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment services are exchanged with Inpatient Substance Abuse services at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Plan will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions Under Mental Health Benefits

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Plan for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription and necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
 - rigid and semirigid custom fabricated orthoses,
 - semirigid prefabricated and flexible orthoses; and
 - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
 - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
 - when the foot orthosis is an integral part of a leg brace and it is necessary for the proper functioning of the brace;
 - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputation) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
 - for persons with neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
 - No more than once every 24 months for persons 19 years of age and older and
 - No more than once every 12 months for persons 18 years of age and under.
 - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluations.
- Infertility drugs are limited to a lifetime maximum of \$5,000 and are obtained through CVS Caremark.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded infertility services:

- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination and variations of these procedures;

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care Services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- Maintenance or preventive the patient's current status;

The following are specifically excluded from Chiropractic Care Services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting; and
- Vitamin therapy.

If multiple outpatient services are provided on the same day they constitute one visit.

A separate Copayment will apply to the services provided by each provider.

Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations.

Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

Reconstructive surgery or therapy is covered if it is intended to correct a physical deformity or disfigurement which is accompanied by a functional deficit. Such coverage will not extend to treatment of abnormalities of the jaw, or conditions related to TMJ disorder, unless such treatment is Medically Necessary. Coverage for Medically Necessary treatment of TMJ disorder will include splints and intraoral prosthetic devices for the repositioning of the bones provided that:

- the surgery or therapy restores or improves function;

- reconstruction is required as a result of Medically Necessary, surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Vision Benefits

Charges incurred by you for a routine vision examination by an eye examination by an Optometrist or an Ophthalmologist;

No payment will be made for more than one examination during a 12-month period.

The Plan will pay you for such expenses up to the Maximum Payment shown in Summary of Benefits.

These benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the vision service if the benefits are provided for that service under:

- this Plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Prescription Drug Benefits

For You and Your Covered Dependents

The Plan provides you with a prescription benefit program administered by CVS Caremark. The CVS Caremark Primary/Preferred Drug List is a guide of medicines within select therapeutic categories. You may take this list along when you or a covered family member sees a doctor. Many medicines are available in a generic form which costs less than their brand name counterparts. The Plan encourages members to use the website www.nccountyhealthplan.org to review the most recent CVS Caremark Primary/Preferred Drug List to determine if your drug is classified as a primary/preferred drug.

The Plan provides that should a member choose a brand name prescription drug and a generic equivalent is available, you may be subject to a reduced benefit and higher out-of-pocket expense. If you choose a brand-name drug and a generic is available, you'll pay the brand copay plus the difference between the generic and the brand-name drug.

In-Network Benefit

The Plan through its relationship with CVS Caremark offers its members an extensive national network of pharmacies to provide participants with pharmacy benefits. The retail network includes both chain and inDependent pharmacies. Your out-of-pocket expense will vary based on whether your prescription is filled in-network, out-of-network, or through mail-order.

To find a local pharmacy in your network, go to www.nccountyhealthplan.org. If you use a network pharmacy, the following diabetic supplies will be covered under your in-network co-insurance and with no deductible:

- Test strips
- Lancets
- Lancet devices
- Insulin Syringes

If you use an out-of-network pharmacy and submit a paper claim, these will be covered and your out-of-network co-insurance will apply.

Covered Medicines Subject to Drug Limitations

Some medicines covered by the plan are subject to maximum dispensing limitations at either a retail pharmacy or through the mail order program. These limits are based on clinically approved prescribing guidelines and are routinely reviewed by CVS Caremark to ensure clinical appropriateness. The limits only affect the amount of medication that your plan will pay for, not whether you can obtain greater quantities.

Your Prescription Drug Program provides coverage for the following:

- Legend drugs, with the exception of those specifically excluded from coverage
- Contraceptives
- Erectile Dysfunction Medications (limits apply)
- Fertility Medications (limits apply)
- Diabetic supplies: Insulin, lancets, lancet devices, test strips, insulin syringes, glucagon
- Emergency allergic kits
- Selected injectable medications
- Over-the-Counter smoking cessation medications

Prescription Drug Plan Exclusions

- Over-the-Counter medications with the exception of those specifically included (varies by plan)
- Allergy Serums
- Cosmetic Products (including but not limited to hair growth stimulants and hair removal agents)
- Nutritional Supplements
- Therapeutic devices or appliances
- Diet medications
- Alcohol wipes
- Glucose Monitors

- Non-insulin syringes (unless specifically included)
- Injectable medications (unless specifically included)

- the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this Plan.

Medical Plan Exclusions and Limitations

Additional coverage limitations determined by the Plan or provider type are shown in Summary of Benefits. Payment for the following is specifically excluded from this Plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- 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 Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this Plan; or

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- regardless of clinical indication for macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries, unless performed to correct a congenital defect; redundant skin surgery, unless performed to correct a congenital defect; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of teeth or periodontium unless such expenses are incurred for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, **when the procedure is related to one of the following conditions:** accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth; congenital deformity, including cleft lip and cleft palate; disease due to infection or tumor, including tumors, cysts and exostosis.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity. Initial treatment of clinically severe (morbid) obesity covered if deemed medically necessary as defined by CIGNA’s Clinical Guidelines. Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, coverage or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
- transsexual surgery including medical or psychological counseling.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction.

- charges for or in connection with the pregnancy of a Dependent, unless the expenses are incurred to treat medical **Complications of Pregnancy**.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages, other disposable medical supplies, and skin preparations, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this Plan.
- private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses or contact lenses unless specifically listed as a covered benefit in your Summary of Benefits. Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
 - charges made for or in connection with eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
 - treatment by acupuncture.
 - all nonprescription drugs, and investigational and experimental drugs, except as provided in the Plan.
 - routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 - membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 - genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
 - dental implants for any condition.
 - fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 - blood administration for the purpose of general improvement in physical condition.
 - cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 - cosmetics, dietary supplements and health and beauty aids.
 - nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
 - medical treatment for a person age 65 or older, who is covered under this Plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
 - medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your immediate family or your Dependent's immediate family.
- to the extent of the exclusions imposed by any certification requirement shown in this Plan.

Pre-existing Condition Limitations

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is covered for these benefits.

Pre-Existing Condition Limitation

A Pre-existing Condition limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under the Plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes covered for benefits. Plan provisions may vary.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered under any creditable coverage within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days or more elapse between coverage under the prior creditable coverage and coverage under this Plan.

Credit for Coverage Under Prior Plan

If you and/or your Dependent(s) were previously covered under a plan which qualifies as Creditable Coverage, the Plan will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under the prior plan(s). However, credit is available only if you notify the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

Certificate of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-Existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent to the Plan.

Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; individual or group health coverage indemnity or HMO plans, Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; a health plan for certain members of the uniformed armed services and their Dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; The Federal Employees Health Benefits Program; a public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children's Health Coverage Program.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

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 medical or vision care or treatment:

- Group coverage and/or group-type coverage, including closed panel coverage, which neither can be purchased by the general public, nor is individually underwritten.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

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

Note: CVS Caremark and the Prescription Drug Program provided to you through this Plan will not coordinate prescription drug benefits with any other coverage.

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 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 confined to a private Hospital room and no plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room 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, 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:

- 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;
- 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;

- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
- 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;
- then, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with custody of the child;
- then, the plan of the parent not having custody of the child, and
- finally, the plan of the spouse of the parent not having custody of the child.
- 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.
- 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.
- 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.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

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:

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

Medicare Eligibles

The Plan will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

1. a former Plan Participant who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
2. a former Plan Participant's Dependent, or a former Plan Participant's Spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
3. a Plan Participant whose Employer and each other Employer participating in the Employer's plan have fewer than 100 employees and that Plan Participant is eligible for Medicare due to disability;
4. the Dependent of a Plan Participant whose Employer and each other Employer participating in the Employer's plan have fewer than 100 employees and that Dependent is eligible for Medicare due to disability;
5. a Plan Participant or a Dependent of a Plan Participant of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age; and
6. a Plan Participant, retired Plan Participant, Plan Participant's Dependent or retired Plan Participant's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him. The Plan strongly recommends that a Participant elect Medicare Parts A and B when first eligible to avoid any future late enrollment penalties.

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 Policy. 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.

Right of Subrogation

You and your Dependents automatically assign to the Plan any rights you may have to recover all or part of the Expenses described above in (1) and (2) of the "Right of Reimbursement" provision ("covered expenses") from any party, including an insurer or another group health program, but limited to the amount of covered expenses paid by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to you or your Dependent or paid to another for your benefit or the benefit of your Dependent. To the extent permitted by applicable law, this assignment applies on a first-dollar basis (i.e., has priority over other rights to such funds); applies whether the funds paid to you or your Dependent, or for the benefit of you or your Dependent, constitute a full or a partial recovery; and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that you or your Dependent may have, whether or not you or your Dependent choose to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

This and any other provisions of the Plan concerning subrogation, rights of reimbursement, equitable liens, and other equitable remedies supersede the applicability of the doctrines commonly referred to as the "make whole" rule and the "common fund" rule (as well as any claimed reduction as a result of "comparative fault" or similar doctrines), regardless of whether such doctrines are created by statute, common law or otherwise, and to the extent permitted by applicable law.

Assistance in Plan's Reimbursement and Subrogation Efforts.

You and your Dependents agree to cooperate with the Plan to effect its subrogation and reimbursement rights, as described herein. You and your Dependents have an obligation to assist the Plan to obtain reimbursement of payments that it has made on behalf of you or your Dependents for which a third party is responsible, and to provide the Plan with any information concerning you or your Dependent's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity

(including insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of you or your Dependents. You and your Dependents are required to (i) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement, (ii) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the reimbursable payments and notifying the Plan), (iii) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement, or other rights, and (iv) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the plan administrator to enforce the Plan's rights. Neither you nor your Dependents may assign any rights or cause of action that you may have against a third-party and that may be subject to the Plan's subrogation and reimbursement/equitable lien rights without the express written consent of the Plan Administrator.

Consequences of Failure to Follow Terms and Conditions

Failure by you or your Dependents to follow the terms and conditions set forth in these provisions governing the Plan's reimbursement and subrogation rights may result, at the discretion of the Plan Administrator, in a reduction of future benefit payments available to you or your Dependents under the Plan of an amount up to the aggregate amount of reimbursable payments that have not been reimbursed to the Plan.

Payment of Benefits

To Whom Payable

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

The Plan may at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider.

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.

Calculation of Covered Expenses

The Plan, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the American Medical Association's Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

Notice Regarding Provider Directories and Provider Networks

You have access to a list of Providers who participate in the network by calling the toll-free telephone number on your ID card or by going to www.ncountyhealthplan.org.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who have agreed to provide care to individuals covered by the Plan.

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.

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.

Coverage for Maternity Hospital Stay

The Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or

newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the Plan or coverage issuer for prescribing a length of stay not in excess of the above periods. The Plan generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Coverage for Mastectomy-Related Services

The Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the toll free number listed on your ID card for more information.

Eligibility

Benefits payable under the Plan are available to you because of your employment or retirement from the Employer as an eligible person. In order for you to participate in the Plan, certain requirements must be satisfied. These requirements may include working a minimum number of hours to be eligible for coverage and a probationary or waiting period. The specific time periods and other standards for participation in the Plan are determined by the Employer or Federal Law.

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: the order recognizes or creates a child's right

to receive group health benefits for which a participant or beneficiary is eligible;

- 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;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- 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

Special Enrollment

Loss of Other Coverage

If you declined enrollment for yourself or your Dependents during your initial enrollment period or an open enrollment period because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan, provided that you request enrollment within 31 days after your other coverage ends and if lost coverage for the following reasons:

- Loss of eligibility for reasons such as divorce, legal separation, death, reaching maximum age limit, losing Dependent status;.
- The employer stopped paying contributions;
- COBRA continuation coverage has ended;
- The Plan no longer provides benefits to the Eligible Person and his/her eligible Dependents; or
- The Eligible Person and/or eligible Dependent exceeds the lifetime limit on all benefits under the plan.

Coverage under this Plan becomes effective on the day immediately following the day coverage under the prior plan

ends if the eligible person does not enroll during an Open Enrollment period (if the employer offers one) and later loses coverage for one of the reasons above.

New Dependent

If you have a new Dependent(s) as a result of marriage, birth, adoption, or placement for adoption you may be eligible to enroll your Dependents in the Plan. Coverage begins on the date of the event provided you request coverage within 31 days after the event.

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.

Michelle's Law

Effective January 1, 2010, the Plan must continue coverage of a Dependent child who is a full-time student for up to one year if the Dependent takes a medically necessary leave of absence from an accredited college or university. A medically necessary leave of absence is one that begins while the Dependent is suffering from a serious illness or injury, is medically necessary, and causes the Dependent to lose student status for purposes of coverage under the Plan. The Plan may not terminate coverage for one year after a medically necessary leave of absence begins or, if earlier, the date coverage would otherwise end under the Plan for all Dependents

SCHIP

Effective April 1, 2009, an eligible person and his or her Dependent also may enroll during a special enrollment period when they lose coverage under Medicaid or under a State Children's Health Insurance Program (SCHIP) or when they become eligible for Medicaid or SCHIP premium assistance.

- Effective April 1, 2009, the Eligible Person and his or her Dependent who is covered under Medicaid or SCHIP and experiences a termination of coverage due to a loss of eligibility may enroll in the Plan if the Eligible Person requests coverage within 60 days after the termination.
- Effective April 1, 2009, the Eligible Person and his/her Dependent who becomes eligible for a premium assistance subsidy under Medicaid or SCHIP may enroll in the Plan if the Eligible Person requests coverage within 60 days after the eligibility determination date.
- Coverage begins on the day immediately following the day coverage under Medicaid or SCHIP ends if the

Eligible Person completes the online enrollment process within 60 days after the termination.

Termination

Your coverage ends on the earliest date of the following events:

1. Reduction in hours; no longer meet the full time employment requirements
2. You terminate employment or retire from employment with the Employer and you are not eligible for retirement benefits.

COBRA Continuation Rights

For You and Your Dependents

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 health 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:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the COBRA 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;
- fraud or misrepresentation of eligibility of any qualified beneficiary; or
- termination of the Plan.

COBRA Notification Responsibilities

It is the Employer's responsibility to provide you and/or your Dependents 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; or
 - (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.
- 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 contribution attributable to the corresponding tier, e.g., Employee-child(ren), Family, Employee Plus One.

When and How to Pay COBRA Contributions

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.

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:

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 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 our 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 medical 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. The appeals process is only available for medical plan denials and does not apply to prescription drugs.

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 the 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.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with the Plan for a different amount.

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.

Complications of Pregnancy

Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including but not limited to: abruption of placenta; acute nephritis; cardiac

decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin Dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. Emergency cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are:

- your lawful spouse;
- domestic partner (varies by Employer); and
- any unmarried child of yours who is
 - less than 19 years of age; or
 - full-time student less than 26 years of age (If student status is required);
 - 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 yearly verification 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.

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

- Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

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 sponsor of the Plan.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;

- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by the Plan; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;

- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.
- The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

- the provider's normal charge for a similar service or supply; or
- 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 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/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare

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

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.
- The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the Plan to provide covered services with regard to the participant.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Plan Participant

The term Plan Participant shall be defined as any eligible employee, retiree, spouse or child covered under the Plan.

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your covered Dependents.

Pre-Existing Condition

A Pre-existing Condition limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under the Plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Review Organization

The term Review Organization refers to an affiliate of the Plan or another entity to which the Plan has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Coverage

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Urgent Care is medical, surgical, Hospital and related health care service and testing which is provided to treat a condition that is: (1) less severe than an Emergency Medical Condition; (2) requires immediate medical attention; and (3) is unforeseen. Care which could have been foreseen as needed before leaving the provider network area where the covered individual ordinarily receives and/or was scheduled to receive

services does not meet the definition of Urgent Care. Such foreseeable care includes, but is not limited to, delivery beyond the 35th week of pregnancy, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the covered individual should not travel due to any medical condition.

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 27603
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