FIRSTCAROLINACARE INSURANCE COMPANY

2016 CERTIFICATE OF COVERAGE

Point of Service Plan

THIS IS A LEGAL CONTRACT. READ THE CERTIFICATE OF COVERAGE CAREFULLY.

IMPORTANT CANCELLATION INFORMATION -- PLEASE READ THE "TERMINATION OF ENROLLMENT" SECTION OF THIS CERTIFICATE FOR MORE INFORMATION.

Special North Carolina Notice

Under North Carolina General Statute Section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance or group health plan premiums, shall: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service corporation plan, multiple employer welfare arrangement, or group health plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay those premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days before the termination of those coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. This written notice must also contain a notice to all persons covered by the group policy of their rights to health insurance conversion policies under Article 53 of Chapter 58 of the General Statutes and their rights to purchase individual policies under the Federal Health Insurance Portability and Accountability Act and under Article 68 of Chapter 58 of the General Statutes. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

WELCOME

Welcome to FirstCarolinaCare Insurance Company (also called FCC). This page has some valuable tips on how get the most from your benefits under the Point of Service Plan. You may choose from a large network of Participating Providers, or may choose to use Non-Participating Providers. You also have access to Specialists without a referral.

THIS CERTIFICATE OF COVERAGE

This Certificate of Coverage ("COC" or “Certificate”), the Schedule of Medical Benefits, any optional riders or endorsements and the application constitute the entire legal agreement between the Member and FCC and govern the conditions of coverage. Please read this COC carefully.

HELPFUL TIPS ON GETTING THE MOST FROM YOUR BENEFITS

Read all information provided, especially this Certificate of Coverage (“Certificate”) and your Schedule of Medical Benefits. Review the Enrollment Information booklet you received when you enrolled. Become familiar with the list of services excluded from coverage (see the Exclusions section).

At the beginning of this Certificate is a list of definitions of important words. It is very helpful to become familiar with these words and their definitions.

Identification cards (ID cards) are provided to all Members. The FCC ID card must be shown when obtaining health care services.

The list of Participating Providers changes from time to time. You should always call in advance to make sure that the Provider is a Participating Provider so In-Network Benefits will be paid by FCC. The list of Participating Providers is available on line at www.firstcarolinacare.com. A printed FCC Provider Directory is available by calling Member Services at the toll free number provided on the ID card and under Important Telephone Numbers in this Certificate.

For questions concerning coverage or Provider information, Member Services is available at the toll free number provided under Important Telephone Numbers section in this Certificate and on the ID card.

You have lower out-of-pocket costs if you choose to use Participating Providers. If Non-Participating Providers are used, Members will have higher Deductibles, Copayments and Coinsurance costs.

Members also must pay the difference between the Non-Participating Provider's Actual Charges and FCC's Maximum Allowable Payment if Non-Participating Providers are used.

You are encouraged to choose a Primary Care Provider (PCP). Although no referral from a PCP is needed to receive Covered Services from a Specialist, PCPs can help manage health care services.

A Nurse Help Line is available 24 hours a day, 365 days a year to provide personal health care advice and support as well as general health information. The number is provided under "Important Telephone Numbers" in the next section of this Certificate and on the ID card.

Pre-certification or Prior Authorization is required on certain Covered Services, as described in this Certificate under the Medical Management section and the Prescription Drug section. It is the Member's responsibility to make sure required Pre-certifications or Prior Authorizations are obtained when required. An additional 20% Coinsurance penalty will be applied to Claims when FCC's Certification requirements are not met. This Certificate and Member Services can answer questions on Certification, Pre-certification or Prior Authorization requirements.

You are encouraged to become involved in your health care treatment by asking Providers about all treatment plans available and their costs. You also are encouraged to take advantage of the preventive health services offered to help you stay healthy and find problems before they become serious.

IMPORTANT INFORMATION ABOUT HEALTH CARE FRAUD PREVENTION

It is estimated that health care fraud costs Americans billions of dollars annually. What can be done to help prevent health fraud? The most important thing is for Members to look carefully at the Explanation of Benefits forms sent to Subscribers by FCC that explain how benefits are paid. Check to make sure that the services are listed accurately and state the services received. If there is a service listed that the Member does not believe he/she received, the Provider should be contacted to see if there was a billing error. If the issue is not resolved or if it is suspected that fraud has occurred, call FCC at 910-715-8100.

Another step to stop health care fraud is to prevent unauthorized use of the FCC ID card. It should be kept in a safe location, just like money, credit cards or other important documents. FCC should be notified immediately if an ID card is lost or stolen.

IMPORTANT TELEPHONE NUMBERS

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

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

Behavioral Services and Substance Abuse
To request Pre-certification of Behavioral or Substance Abuse services call Member Services at: **800-574-8556 (toll free)**

Pre-certification - Medical
To request Pre-certification or for questions related to Pre-certification for medical services, call

Member Services at: **800-574-8556 (toll free)**

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

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

FirstCarolinaCare Insurance Company - Main Office
For any additional questions or information, call Member Services at: **800-574-8556 (toll free) or 910-715-8100**

NC Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212

Health Insurance Smart NC
The North Carolina Department of Insurance developed Health Insurance Smart NC to help North Carolinians better understand their options and rights related to health insurance. If you need help finding health insurance or resolving a dispute with FCC, or if you want to find out more about what the health care laws mean to you, contact Health Insurance Smart NC.

The staff of health insurance specialists works out of the Department of Insurance office Raleigh as well as from the regional office in Asheville. To reach Health Insurance Smart NC, contact:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: 855-408-1212

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POINT OF SERVICE PLAN

This Point of Service Plan was selected by the Employer, which signed a Master Employer Agreement with FCC.

This Certificate of Coverage ("Certificate"), the Schedule of Medical Benefits and the Master Employer Agreement govern the conditions of coverage.

FCC will pay for Covered Services received by a Member. The amount payable is subject to the terms of this Certificate, the Schedule of Medical Benefits and the Master Employer Agreement.

DEFINITIONS

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

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

Annual Enrollment Period- the period occurring every year on the anniversary of the Open Enrollment Period during which Eligible Employees can elect to enroll themselves or Eligible Dependents in FCC, or Members can change or terminate enrollment.

Appeal - a request for review of a Noncertification.

Approved Clinical Trial - a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-threatening Condition and is described in A, B. or C below:

(A) Federally Funded Trials - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
- (i) The National Institutes of Health.
- (ii) The Centers for Disease Control and Prevention.
- (iii) The Agency for Health Care Research and Quality.
- (iv) The Centers for Medicare & Medicaid Services.
- (v) Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
- (vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- (vii) Any of the following, so long as the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  - (I) The Department of Veterans Affairs.
  - (II) The Department of Defense.
  - (III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug

application reviewed by the Food and Drug Administration.
(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Autism Spectrum Disorder – as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. Autism Spectrum Disorder is not considered a Mental Illness.

Behavioral Health Services - services to treat a Mental Illness.

Brand Name Drug - a Prescription Drug that is identified as an original trademarked product.

Certification or Certified - a determination by FCC that a Hospital admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies FCC's criteria for Medically Necessary services and supplies, appropriateness, health care setting, level of care and effectiveness. (See the definitions of "Pre-certification" and "Noncertification" for additional information.)

Claim - a request for payment for Covered Services in a form required by FCC.

Coinsurance - a set percent of the Maximum Allowable Payment that members pay a Provider for a Covered Service (for example, 20%).

Complications of Pregnancy - medical conditions whose diagnoses are separate from pregnancy, but may be caused or made more serious by pregnancy, resulting in the mother's life or health being in jeopardy or making a live birth less viable. Examples include:

- Abruption of placenta;
- Acute nephritis;
- Pre-eclampsia or eclampsia;
- Placenta previa;
- Poor fetal growth;
- Kidney infection;
- Emergency caesarian section, if provided in the course of treatment for a Complication of Pregnancy.

The following conditions are not Complications of Pregnancy:

- Labor (whether or not resulting in delivery) and delivery;
- Occasional spotting;
- Symptoms that cause the Provider to order bed rest; and
- Morning sickness.

Copayment - a fixed dollar amount a Member must pay a Provider for certain Covered Services based on the Schedule of Medical Benefits.

Cover or Covered - eligible for benefits under this Certificate.

Covered Services - health care services, items and supplies that meet all the conditions for coverage under this Certificate.

Creditable Coverage - with respect to an individual, coverage of the individual under any of the following:

a. A group health plan.

b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.

c. Part A or part B of title XVIII of the Social Security Act.

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

e. Chapter 55 of title 10, United States Code.

f. A medical care program of the Indian Health Service or of a tribal organization.

g. A State health benefits risk pool.

h. A health plan offered under chapter 89 of title 5, United States Code.

i. A public health plan (as defined in federal regulations).

j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable Coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered Creditable Coverage.

Custodial Care - care needed to protect or maintain a stable level of function in a patient whose general condition and physical findings remain substantially constant and in which no improvement is expected.

Deductible - an amount of money paid by the Member for Covered Services before FCC starts paying benefits.

Dental Services - professional services for the diagnosis and treatment of disease or defects, or accidental injury to the teeth, gums and the alveolar structure. Dental Services include examinations, and consultations and hospitalization for dental related care.

Eligible Dependent - a person who is neither on active duty in the armed services nor incarcerated and is either:

- the Subscriber's legal spouse: who is living in the same residence as the Subscriber and not legally separated from the Subscriber; or
- a child, under age 26, who is either:
  - a stepchild of the Subscriber;
  - a child placed with the Subscriber in a foster home as described in NCGS § 58-51-30) (that is, for whom the Subscriber has assumed a legal obligation for total or partial support);
  - a natural or adopted child of the Subscriber, or a child placed with the Subscriber for adoption (as defined in NCGS § 58-51-125(a)(2)) regardless of whether or not such child is living in the same residence with the Subscriber; or
- the Subscriber's child who is 26 years old or older and:
  - is not capable of self-support as a result of mental retardation or a physical handicap, subject to the following conditions:
    - the child must have become incapable prior to his or her 26th birthday and must be enrolled with FCC when he or she reaches age 26 and be chiefly dependent on the Subscriber for support;
    - the child continues to stay in the condition described above; or
- the subject of a Qualified Medical Child Support Order that is not inconsistent with this definition.

Eligible Employee – a bona fide employee (excluding independent contractors) designated by the Employer as eligible for health benefits. All Eligible Employees must reside or work in the Service Area.

Emergency Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic

medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

Employer - the employer group to which the Master Employer Agreement is issued and who established coverage under this Certificate.

Enrollment Date - the date when a person is enrolled as a Member and eligible for benefits under this Certificate, or the first day of any applicable Waiting Period, if earlier. The Enrollment Date does not change if the Member changes benefit packages or if the Employer changes health insurers.

Experimental/Investigational - Except as otherwise described for Covered Clinical Trials and Approved Clinical Trials, treatments, procedures, devices, drugs, or medicines for which one or more of the following is true, as determined by FCC:

- Reliable evidence shows that the treatment, procedure, device, drug or medicine is:
  - the subject of ongoing clinical trials; or
  - under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that experts agree that further studies or clinical trials are needed on the treatment, procedure, device, drug, or medicine. These studies would test the safety and effectiveness of the treatment compared to other accepted treatment.
- Is not approved for sale by the U.S. Food and Drug Administration (FDA) or is not approved by the FDA for use other than that defined under the terms of the FDA approval. A drug will not be considered experimental or investigational if it is approved by the FDA for treatment of a type of cancer and the Provider prescribes the drug for the treatment of another type of cancer so long as the drug has been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following:
  - The National Comprehensive Cancer Network Drugs and Biologics Compendium;
  - The Thomson Micromedex DrugDex;
  - The Elsevier Gold Standard's Clinical Pharmacology; or
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

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For purposes of this definition "reliable evidence" means:

- published reports and articles in medical and scientific literature;
- the written protocol(s) used by the treating facility or the protocol(s) of another facility studying the same treatment, procedure, device, drug, or medicine; or
- the written informed consent used by the treating facility or by another facility studying the same treatment, procedure, device, drug, or medicine.

Explanation of Benefits ("EOB") – a statement sent by the insurance company to a Member explaining what requests for coverage for medical treatments and/or services were processed on his or her behalf.

Formulary - a list that identifies those Prescription Drugs that are preferred by FCC or FCC's designee for dispensing to Members.

Generic Drug - a Prescription Drug that contains the same strength and dosage of the same active ingredient(s) as a Brand Name Drug and that is determined by the FDA to be therapeutically equivalent to the Brand Name Drug.

Grievance - a written complaint submitted by a Member about any of the following:

- FCC's decisions, policies or actions related to availability, delivery or quality of health care services. A written complaint submitted by a Member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a Grievance if the exclusion of the specific service requested is clearly stated in this Certificate;
- Claims payment or handling, or reimbursement for services;
- The contractual relationship between a Member and FCC; or
- The outcome of an appeal of a Noncertification.

Hospital - an accredited, state licensed facility where sick and injured people are treated on an inpatient and outpatient basis. Hospitals must provide physicians on call 24 hours a day and staffing by nurses 24 hours a day.

In-Network Benefits - the benefits paid for Covered Services received by a Member from a Participating Provider (or a Non-Participating Provider if the service is unavailable from a Participating Provider).

Late Enrollee - a person who does not enroll in FCC during:

- the Open Enrollment Period, or
- if a new hire or a newly Eligible Employee, the 31 day period following the date on which he/she was first eligible to enroll; or
- a Special Enrollment Period, when applicable.

Life-threatening Condition - any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Maximum Allowable Payment ("MAP")- the lesser of:

- the Provider's Actual Charge for the service or supply; or
- the current provider reimbursement amount established by FCC

Medically Necessary or Medical Necessity - Covered Services that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, Injury, or disease; and
- Except as described for Covered Clinical Trials and Approved Clinical Trials, not for Experimental/Investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, care, or relief of a health condition, illness, Injury, disease or its symptoms.
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of the Member, the Member's family or the Provider.

Nothing in this definition prevents FCC from comparing the cost of different services or supplies when deciding the services or supplies to be Covered.

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

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

be provided or supervised by one of the following licensed professionals, so long as the services or supervision provided is commensurate with the licensed professional's training, experience, and scope of practice:

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

Member - a person who has met all of the eligibility requirements and is entitled to receive Covered Services under this Certificate.

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

Mental retardation means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22.

Narrow Therapeutic Index Drug - a Prescription Drug having a narrowly defined range between risk and benefit. These Prescription Drugs are designated as Narrow Therapeutic Index Drugs by the North Carolina Secretary of Health and Human Services, and a listing is available from the North Carolina Board of Pharmacy.

Noncertification - a determination by FCC that a Hospital admission, availability of care, continued stay, or other health care service, item or supply has been reviewed and, based upon the information provided, does not meet FCC's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of Emergency Medical Condition, and the requested service is therefore denied, reduced, or terminated. A Noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in this Certificate. A Noncertification includes any situation in which FCC makes a decision about a Member's condition to determine whether a requested treatment is Experimental/Investigational, or cosmetic, if the extent of coverage under this plan is affected by that decision.

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

Notice of Extension - a notice sent after FCC determines that an extension of time is necessary due to the lack of information necessary to make the benefit determination.

Open Enrollment Period - the period when Eligible Employees and Eligible Dependents are first offered

the opportunity to enroll in FCC.

Out-of-Network Benefits - the benefits paid for Covered Services received from a Non-Participating Provider when those Covered Services are available from a Participating Provider.

Out-of-Pocket Maximum - the maximum amount of Copayments, Deductibles and Coinsurance required to be paid by the Member for Covered Services measured on a benefit year basis. It does not include any amounts paid by the Member for charges in excess of the Maximum Allowable Payment.

Participating Provider - a Provider who has a contract with FCC to provide certain Covered Services to Members.

Pre-certification - a Certification requested from and issued by FCC before the Member receives health care services.

Prescribed Contraceptive Drugs or Devices - drugs or devices that prevent pregnancy.

Prescription Drug - means any drug, product or device approved by the U.S. Food and Drug Administration, and required by law to be dispensed only by prescription, and which is dispensed pursuant to a Prescription Order and/or Refill.

Prescription Order and/or Refill - the directive to dispense a Prescription Drug issued by a licensed health care provider whose license and scope of practice permits issuing such a directive.

Primary Care Provider (PCP) - a Provider who:

- is practicing family or general medicine, obstetrics and gynecology, internal medicine or pediatrics; or, is a specialist when the Member has a serious or chronic degenerative, disabling or Life-threatening Condition (the Member's Copayment amount is not changed in such event);
- is chosen by the Member to be responsible for coordinating the overall health care needs of the Member; and
- is a Participating Provider.

Prior Authorization - the process of obtaining a Certification of coverage for Restricted Access Prescription Drugs or Devices or quantities of certain Prescription Drugs before they are dispensed using guidelines approved by FCC.

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

Qualified Medical Child Support Order (QMCSO) - an order by the court that requires a Subscriber to provide medical benefits for a child.

Restricted Access Prescription Drugs or Devices - those Covered Prescription Drugs or devices that require Prior Authorization or the use of alternative drugs or devices before FCC will pay benefits.

Service Area - the North Carolina counties in which FCC is authorized to offer coverage and can offer an adequate and accessible Provider network, including Anson, Chatham, Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Robeson, and Scotland counties.

Sexual Dysfunction - any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

Special Enrollment/Enrollee - an enrollment by an Eligible Employee or an Eligible Dependent who meets certain conditions.

Specialist - a Provider other than a Primary Care Provider; "Specialist" includes a sub-specialist.

Subscriber - an Eligible Employee properly enrolled in the health benefit plan of the Employer.

Substance Abuse Services – health services to treat the misuse of alcohol or other substances, including Prescription Drugs that cause physical and/or psychological addiction.

Urgent Care Provider – an outpatient Provider that provides services for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis and treatment, such that without such care the individual reasonably could be expected to suffer chronic illness, prolonged impairment or require more hazardous treatment. Examples include sprains, some lacerations and dizziness.

Waiting Period – a time period established by the Employer that must be satisfied before an employee may be an Eligible Employee and may enroll for benefits under this Certificate, not to exceed ninety (90) days. Waiting Period does not include any period before an individual's Late or Special Enrollment.

ELIGIBILITY AND ENROLLMENT

Subscriber Enrollment

Only an Eligible Employee can enroll as a Subscriber. If a husband and wife are both Eligible Employees, the Employer will determine whether both spouses may choose to enroll as Subscribers, or if one must elect to enroll as an Eligible Dependent.

Employers hold only one Open Enrollment Period. Except for the events described below, after the Open Enrollment Period, Eligible Employees generally may enroll only during the Annual Enrollment Period. Those who enroll for the first time during an Annual Enrollment Period will be considered Late Enrollees.

For new hires, the Employer will determine when an employee is eligible to enroll. The Employer may have a Waiting Period that must be satisfied before coverage is in effect. Enrollment must be within 31 days from the date the Eligible Employee is first eligible for coverage.

The Enrollment Date will be the date that the employee is first eligible to enroll, if he/she enrolls on or before that date. If enrollment is after the eligibility date, the Enrollment Date will be the first of the next month. For example, if an employee is first eligible on May 21 and he/she enrolls on June 3, the Enrollment Date is July 1.

Enrollment forms and other authorizations, as required by FCC, must be completed in order for coverage to become effective. ID cards will be issued to each Member with the Enrollment Date and other important information about benefits.

Dependent Enrollment

Only Eligible Dependents may be enrolled by the Subscriber. If a Subscriber has an Eligible Dependent that he/she wishes to enroll at the same time the Subscriber enrolls, the Enrollment Date for the Eligible Dependent will be the same as the Subscriber's if enrolled within 31 days of the date the Subscriber was first eligible to enroll.

Eligible Dependents acquired after the Subscriber's enrollment due to marriage, birth, adoption or

placement for adoption or in a foster home may be enrolled within 31 days of the date of those events.

If enrolled within 31 days after the date of birth, adoption or placement for adoption or in a foster home, then the Enrollment Date will be the same as the date of the event. This enrollment time limit is waived for newborns, adopted children, children placed for adoption or foster children if there is no change in the premium. Nevertheless, FCC should be notified of the newly acquired child as soon as possible to ensure that Claims are paid properly.

If enrolled within 31 days after the date of marriage, the Enrollment Date for an Eligible Dependent added due to marriage will be the date of the Subscriber's timely request to enroll an Eligible Dependent due to marriage (or earlier if permitted by the Employer). However, in no event will the enrollment be effective prior to the date of the marriage.

If a newly acquired Eligible Dependent is not enrolled within 31 days after the event, he/she may not enroll until the next Annual Enrollment Period and will be considered a Late Enrollee. The 31 day limit does not apply if an enrollment is due to a Qualified Medical Child Support Order (explained below).

Unless an event described in the sections below occurs, after the Open Enrollment Period, Eligible Dependents generally may enroll only during the Annual Enrollment Period. Those who enroll during an Annual Enrollment Period for the first time will be considered Late Enrollees.

FCC may request proof of Eligible Dependent status annually. For any person who is past the usual dependent age limit but is not capable of self-support as a result of mental retardation or a physical handicap (as described under the definition of Eligible Dependent), proof of such mental retardation or physical handicap will be required within 31 days of the child's attainment of the limiting age. Thereafter, FCC may require proof that such mental retardation or physical handicap continues, but such proof will not be required more frequently than annually. If proof of Eligible Dependent status or verification of mental retardation or physical handicap is not provided when requested, the dependent may not be enrolled or may be disenrolled.

Qualified Medical Child Support Orders
A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order that is issued by a court or through an administrative procedure that provides for health coverage for a child and is issued according to state law or under the Social Security Act. A QMCSO must be specific as to the plan in which the child is to be enrolled, the type of coverage, the child(ren) to be enrolled and the length of coverage. It is the responsibility of the Employer to determine if a child is eligible under a QMCSO.

Special Enrollment
Eligible Employees and their Eligible Dependents may enroll at certain times other than during the Open Enrollment Period or Annual Enrollment Period. Special Enrollment rights apply if an Eligible Employee or Eligible Dependent did not enroll in FCC when first eligible because he/she was enrolled in another health plan and loses coverage due to:

- termination of employment or reduction in hours;
- termination of the other plan or the Employer contribution;
- death of the other employee;
- legal separation or divorce;
- loss of eligibility;
- residing, living or working outside of an HMO service area with no other coverage option;
- uniform termination of coverage by the insurer;
- cessation of benefits to a class of similarly situated individuals including the Eligible Employee or Eligible Dependent;
- exceeding the lifetime limits on benefits; or
- exhaustion of COBRA coverage.

In addition to the loss of coverage events triggering the Special Enrollment rights listed above, if an Eligible Employee who previously did not enroll adds an Eligible Dependent due to marriage, birth, adoption or placement of an adopted child or a foster child, both the Eligible Employee and Eligible Dependents may enroll as Special Enrollees.

All Special Enrollments due to the reasons listed above must be requested within 31 days of the events described above.

Additionally, Eligible Employees and Eligible Dependents may enroll as Special Enrollees if:

- Eligible Dependents were enrolled in a state children's health insurance program, and they lose eligibility for that coverage, or
- They become eligible for premium assistance under Medicaid or the state children's health insurance program.

Special Enrollments for the two reasons listed above must be requested within 60 days from the events.

If a Member enrolls during a Special Enrollment period, that Member is a Special Enrollee even if the enrollment coincides with a late enrollment opportunity.

Other Enrollment Changes

In addition to occurrences of the events described above, a Subscriber may add, change or terminate his/her or his/her Eligible Dependent's enrollment for any of the occurrences listed below:

- Divorce;
- Death;
- Coverage under another employer-sponsored plan has a significant change in cost or benefits;
- Addition of a step-child as an Eligible Dependent;
- Change from civilian status to active military personnel;
- Termination of a QMCSO;
- Loss of Eligible Dependent status; or
- Eligibility for Medicare or Medicaid.

The Subscriber must notify FCC in writing within 31 days of the above events. Subscribers should contact the Employer's Human Resources manager as soon as one of these events occurs and request a change form.

To make sure Subscribers receive all FCC communications, please notify FCC when there is an address or name change.

Certificates Of Creditable Coverage

When a Member disenrolls from FCC, including at the end of a continuation coverage period, FCC will provide a certificate of Creditable Coverage so that the Member can show proof of Creditable Coverage. Members also may request a certificate of Creditable Coverage from FCC up to 24 months from the date of disenrollment.

Termination of Enrollment

Enrollment of all Members ends on the date on which the Master Employer Agreement is terminated.

Disenrollment due to termination from employment takes effect on the last day of employment, unless the Employer elects otherwise.

Enrollment of a dependent ends when he/she is no longer an Eligible Dependent, such as when he/she reaches the maximum age. The date of disenrollment is the last day of the month in which eligibility is

lost, unless the Employer elects otherwise. The Employer also may elect to end dependent coverage. The date of disenrollment will be the last day of the month in which premiums for dependent coverage are paid.

If enrollment ends because of termination of employment, reduction in hours or loss of Eligible Dependent status, Members may elect continuation coverage. See the "Continuation Coverage and Conversion Privilege" section of this Certificate.

A Member also may be disenrolled upon written notice by FCC for the following:

- Knowingly providing false or incomplete information to FCC with fraudulent intent;
- Engaging in conduct that interferes with providing Covered Services; or
- Permitting the use of the FCC ID card by another person.

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

Except where continuation coverage is elected, FCC has no responsibility for payment for any health services provided after the date of disenrollment, regardless of the reason for disenrollment.

GENERAL INFORMATION ABOUT BENEFITS

Understanding a Point of Service Plan

Under this Point of Service plan, Members may choose to receive most Covered Services from either a Participating Provider or a Non-Participating Provider. As the Schedule of Medical Benefits shows, using Non-Participating Providers usually costs more for the Member than using Participating Providers. Generally, Covered Services provided by Non-Participating Providers are paid as Out-of-Network Benefits. Also, Covered Services provided in an emergency room that are not Emergency Services will be paid as Out-of-Network Benefits. This rule applies even if the Member is an Eligible Dependent who does not live or work near Participating Providers, such as when he or she is living in a dormitory at school.

Emergency Services and services provided by an Urgent Care Provider always will be paid as In-Network Benefits. Therefore, as illustrated in the example below, the Member is not responsible for the difference, if any, between the Actual Charges and the Maximum Allowable Payment.

Covered Services received from Non-Participating Providers will be paid as In-Network Benefits if a Participating Provider is not able to meet the health needs of a Member without unreasonable delay as determined by FCC's network access standards. If the Member believes that a Participating Provider is not available without unreasonable delay, the Member is encouraged to contact FCC prior to receiving services from a Non-Participating Provider. FCC will tell the Member whether In-Network Benefits will be applied.

Important Note: Out-of-Network Benefits are not available for certain Covered Services. In order to be paid by FCC, the following Covered Services must be received from a Participating Provider:

- Services listed under the “Wellness and Preventive Services” section of this Certificate; and
- Organ and tissue transplants

Member Cost Sharing

Member payments, such as Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums, are listed on the Schedule of Medical Benefits. Most Covered Services require a payment to the Provider by the Member at the time of service. Deductibles are calculated and re-set on a yearly basis, regardless of the Enrollment Date. Usually, the yearly basis is a calendar year (January 1 to December 31), but the Employer may change the measurement period to the plan year. Please note that there are separate

Out-of-Pocket Maximums for Prescription Drugs and for Covered Services other than Prescription Drugs.

In-Network Benefits

When an In-Network Benefit is based on a Coinsurance instead of a Copayment, FCC calculates the Member's payment obligations on the negotiated rate with the Participating Provider. The Member is not responsible for the difference, if any, between the Participating Provider's Actual Charges and the negotiated rate. The following is an example of the calculation for In-Network Benefits if the Member's Coinsurance is 20% (note, this example assumes the Member has already paid all applicable Deductibles and Copayments):

Actual Charges	$1200
Maximum Allowable Payment (MAP)	$1000
Coinsurance Amount (20% of MAP)	$200
Member Cost	$200

If the Member also has a Copayment, the Copayment is first subtracted from the contract rate, then the Coinsurance is calculated on the remaining amount.

Out-of-Network Benefits

When Covered Services are received from a Non-Participating Provider and Out-of-Network Benefits apply. Coinsurance will be calculated on the Maximum Allowable Payment -- not on Actual Charges. When Covered Services are received from an emergency room but the services are not Emergency Services, Out-of-Network Benefits will apply. The Member may be billed for the difference, if any, between the Actual Charges and the Maximum Allowable Payment and this difference is not applied to the Out-of-Pocket Maximum. Please see the example below (note, this example assumes the Member has already paid all applicable Deductibles and Copayments):

Actual Charges	$1200
MAP	$1000
Difference Between Actual Charges and MAP	$200
Coinsurance (20% of MAP)	$200
Member Cost	$400

REQUIRED NORTH CAROLINA NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance or Copayment amount because actual Provider charges may not be used to determine FCC's and Member's payment obligations.

About Selecting Providers

A Provider Directory is available upon request and at www.firstcarolinacare.com. Participating Providers change from time to time. Just because a Participating Provider is listed in the Provider Directory does not guarantee that the Provider is still in FCC's network at the time services are provided. It is recommended that Members call FCC Member Services to confirm a Provider's status.

Primary Care Providers

Members are encouraged to choose a Primary Care Provider (PCP) from the list of Participating Providers. The PCP will provide primary care services and may help coordinate specialty and hospital care when needed. PCPs are trained to deal with a broad range of health care needs.

Specialists

No referral from FCC is required for Members to see a Specialist. However, Pre-certification requirements may apply depending on the services received. Please see Attachment A at the end of this Certificate for services requiring Pre-certification.

Continuity of Service
As a service to Point of Service Members, FCC will allow a newly enrolled Member to continue receiving services from a Non-Participating Provider and be eligible for In-Network Benefits for up to 90 days from his/her Enrollment Date. The Non-Participating Provider must agree to accept as payment in full the Maximum Allowable Payment and to comply with FCC policies and procedures. Members must notify FCC if they wish to have this option.

COVERED SERVICES

General Coverage Rules
Only health care services and supplies for an illness or injury are Covered Services, and only when all the following conditions apply:

- The service or supply is listed as a Covered Service in this Certificate and meets all conditions in this Certificate;
- The recipient is a Member of FCC when he or she receives the service or supply;
- The Member receives the service or supply from a Provider;
- The service or supply is furnished in an appropriate health care facility or location; and
- The service or supply is Medically Necessary.

Wellness and Preventive Services
The following are Covered Services only when received from a Participating Provider. Cost sharing does not apply (e.g. Copayments, Deductibles, Coinsurance) except as indicated below with *** unless other services are provided during the same visit as the preventive services. For example, if a service listed below is provided during an office visit and that service is not the purpose of the visit, the Member cost sharing amount that would otherwise apply to the office visit will still apply.

FCC provides coverage for preventive care services in accordance with the requirements of federal and state law. A full list of covered preventive care items and services may be found at healthcare.gov/center/regulations/prevention.html. If a preventive care item or service in the website listing or as described below does not specify a limitation on the frequency, method, treatment or setting, FCC may apply reasonable limitations and other medical management requirements. Contact Member Services for additional information.

Adults

- Alcohol Misuse screening and counseling
- Aspirin use for adults of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer examinations and laboratory tests for cancer, in accordance with the American Cancer Society guidelines, for any non-symptomatic Member who is at least 50 years of age, or less than 50 years of age and at high risk for colorectal cancer
- Depression screening
- Type 2 Diabetes screening for adults with high blood pressure
- Behavioral dietary counseling for adults with cholesterol disorders and other known risk factors for cardiovascular and diet-related chronic diseases
- HIV screening for all adults at higher risk
- Diabetes outpatient self-management training and educational services
- Immunizations according to Advisory Committee on Immunization Practices recommendations
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and certain cessation medication for tobacco users
- Syphilis screening for all adults at higher risk

Women Only

- Annual well-woman visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception care and many services necessary for prenatal care. (Additional visits if physician determines more than one visit is required to provide the recommended preventive services)
- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Folic Acid supplements (at clinically appropriate strengths) for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk
- Surveillance tests for women at risk for ovarian cancer. "Surveillance tests" mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination.
- The following prevention-related health services:
  - Breastfeeding support and counseling for pregnant and postpartum nursing women from a trained Provider and one electric or manual breast pump per pregnancy (hospital grade pumps are not Covered)
  - Domestic and interpersonal violence screening and counseling
  - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
  - Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
  - Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
  - Sexually Transmitted Infections (STI) counseling for sexually active women
- Education and counseling on contraceptive methods and sterilization procedures for women with reproductive capacity.
- Of the following contraceptive methods, at least one item of each method will be Covered for a female Member of reproductive capacity and the item will be Covered at 100%; over the counter items are Covered only when a prescription for the female Member is presented. If FCC Covers a generic version, the corresponding brand version will continue to require Member cost sharing per benefit plan (Copayment, Deductible, and/or Coinsurance) unless the Member follows the exception process outlined under the Prescription Drugs section. Up to a 30 day supply will be covered per prescription, unless otherwise required or limited due to product packaging, approved dosage and dosage form.
  - Cervical Caps
  - Diaphragms and sponges
  - Implantable rods
  - IUDs
  - Condoms and spermicide
  - Emergency contraception medication
  - Medroxyprogesterone 150mg injection
  - Oral contraceptives
  - Patch
  - Vaginal contraceptive ring

- Surgical sterilization
- Surgical sterilization implant

Men Only

- Prostate specific antigen (PSA) tests when a Provider recommends it;
- One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked
- Vasectomy for surgical sterilization is Covered *** Member cost sharing applies

Infants and Children Only

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Blood Pressure screening for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children age 6 and under without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns and at recommended intervals for children
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization according to Advisory Committee on Immunization Practices recommendations
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling, including medical nutritional counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for children under 6 years for amblyopia, strabismus and defects in visual acuity
- Vision screenings at recommended intervals for children age 6 and above

Physician Services and Office Visits

Examinations, treatment and consultations by a PCP or a Specialist are Covered Services. Covered Services also includes items and supplies provided or administered during an office visit, except for oral medications.

Emergency Services

If a Member believes that he/she has an Emergency Medical Condition, he/she should seek care from the nearest Provider. "911" emergency telephone access systems or other community emergency alert systems should be used where available. Emergency Services will be paid at the In-Network Benefits amount whether services are received at a Participating or Non-Participating Provider.

Examples of Emergency Medical Conditions include, but are not limited to, suspected heart attacks or strokes, uncontrolled bleeding, poisoning, major burns, prolonged loss of consciousness, head or spinal

injuries, shock, or other acute conditions.

Coverage will be provided for treatment of Emergency Medical Conditions, without Pre-certification, until the Member's condition is stabilized. Services ordered by an emergency department Provider but received after stabilization may require Pre-certification, e.g. an MRI or CT scan.

For routine and follow up care related to an Emergency Medical Condition to be eligible for In-Network Benefits, the Member must use a Participating Provider. Pre-certification requirements may apply.

If a Member is admitted for a Hospital stay directly from the emergency department, FCC should be notified of the condition and the services that the Member is receiving as soon as medically appropriate by calling the toll free Member Services number. The Hospital stay will be paid at the In-Network Benefits amount until the Member can be transferred to a Participating Provider. If the Member does not transfer to a Participating Provider when medically appropriate, then FCC may, at its option, determine that Out-of-Network Benefits will be paid for the remaining Hospital stay.

Services received from an Urgent Care Provider are Covered at In-Network Benefits.

If a Member is unsure whether a condition is an Emergency Medical Condition or could be treated at an Urgent Care Provider or other Provider's office, he/she can call the Nurse Help Line. The number is listed on the "Important Telephone Numbers" page.

Hospital Services Other than Maternity Care
Hospital admissions are Covered, including all Medically Necessary services and supplies furnished by the Hospital, Provider services, diagnostic services and room and board for a semi-private room. Room and board for a private room is Covered if:

- The Member's condition requires he/she be isolated;
- Use of a private room is Medically Necessary; or
- The Member is admitted to a Hospital that only has private rooms.

Outpatient Services and Surgery
FCC will Cover health services provided in an outpatient setting in a licensed facility, such as chemotherapy, infusion, diagnostic procedures and ambulatory surgery.

Skilled Nursing Facility Services
Skilled nursing facility services, including room, board and Medically Necessary supplies, are Covered if:

- The Member's Provider recommends the services;
- The services follow a Hospital stay for recovery from an injury or sickness or takes the place of a Hospital stay that would be required if the services were not provided;
- The Member is under the continuous care of a Provider; and
- The Member's Provider certifies that the Member needs 24 hour nursing care.

The total number of days in a skilled nursing facility Covered "per cause" are listed in the Schedule of Medical Benefits. "Per cause" means stays in a skilled nursing facility that are a result of the same or related cause, as well as stays separated by less than 3 months.

Coverage for Certain Treatment of Diabetes
Coverage will be provided for diabetes outpatient self-management training and educational services, equipment, supplies and laboratory procedures used to treat diabetes.

Home Health Care
Home health care is Covered if services are:

- Non-Custodial Care provided in the home;

- Provided by health professionals;
- Supervised by a Provider;
- Provided by a home health care Provider approved by FCC; and
- Provided to a Member Precertified by FCC as homebound; that is, unable to leave home for more than short, infrequent non-medical purposes without considerable and taxing effort.

Short-term Outpatient Rehabilitation Services
Short-term outpatient occupational therapy and physical therapy are Covered. Short-term speech therapy to restore speech loss only due to sickness or injury is Covered. Members may receive services in a Hospital outpatient department, Providers' office, or a freestanding therapy center. All rehabilitation services are Covered only for conditions that, in FCC's judgment, are reasonably expected to improve in the short-term, i.e. 6 months or less. The Schedule of Medical Benefits lists the limits for each service.

Chiropractic Services
Chiropractic services are Covered for conditions that, in FCC's judgment, are reasonably expected to improve in the short term, i.e. 6 months or less. The Schedule of Medical Benefits lists the limits to each service.

Imaging and Laboratory Procedures
Imaging and laboratory services at freestanding health care facilities, Hospital outpatient departments or Providers' offices are Covered. This includes:
- X-rays to diagnose or treat conditions,
- Fluoroscopy, ultrasound, EEGs, EKGs,
- MRIs, PET and CT scans,
- Laboratory tests,
- Amniocentesis with associated tests needed to make a treatment decision, and
- Genetic testing if the Member is symptomatic and testing is needed to make a treatment decision.

Reproduction Related Services

Maternity Care

Maternity care is Covered only for the Subscriber and the Subscriber's spouse (if the spouse is a Member). Covered Services include:
- Prenatal care (including testing for cystic fibrosis);
- Hospital stays;
- Birthing center care;
- Attending Provider services;
- Post-delivery care for the mother and baby if the mother and attending Provider agree to a discharge prior to 48 hours after normal delivery or for up to 96 hours after cesarean section; and
- Services for the baby for the duration of the mother's Hospital stay after childbirth.

Post-delivery care is health care provided to a mother and her newborn child whose Hospital stay (upon the Member's attending Provider decision in consultation with the Member) is less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. Such care must be by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in any of the following appropriate location(s) as deemed appropriate by the Member's Provider: (1) the home, a Provider's office, a Hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under federal regulations promulgated under Title VI to Public Law 104-204.

No Pre-certification is required for Hospital stays for the mother and baby for up to 48 hours after normal delivery or for up to 96 hours after caesarean section. Hospital stays in excess of those periods require Pre-certification.

FCC will apply routine order of benefit procedures if the newborn has other valid primary coverage that covers, without requiring Certification, the 48 hours of inpatient stay following a normal vaginal delivery or 96 hours of inpatient stay following a cesarean section.

Complications of Pregnancy

Complications of Pregnancy are Covered for all Eligible Dependents, not just spouses. Health services for a Member's Complication of Pregnancy are not maternity care and are Covered for all Members on the same terms that apply to any other sickness or injury.

Diagnosis of Infertility

Services related to the diagnosis of infertility are Covered. Treatment of infertility is not a Covered Service. See Exclusions and Limitations for excluded infertility services.

Family Planning

Covered Services include examinations, consultations, procedures and other services relating to the use of contraceptive methods for the prevention of pregnancy. Covered contraceptives are listed under "Wellness and Preventive Services"

Autism Spectrum Disorder Services

For Members age 18 years or younger, screening, diagnosis and treatment of Autism Spectrum Disorder with a date of service after July 1, 2016 are Covered. Subject to the conditions listed below, Covered Services include:

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

Coverage is subject to the Copayment, Deductible, and Coinsurance provisions stated in the Member's Schedule of Benefits that apply to primary care or specialist physician services (as appropriate to the license of the treating provider) in an office visit / outpatient setting. Coverage may not be denied on the basis that the treatments are habilitative or educational in nature. Benefits are subject to a maximum benefit of up to forty thousand dollars ($40,000) per year. Beginning in 2017 and for subsequent years, the amount shall be indexed using the Consumer Price Index for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of March of the year preceding the change divided by the index as of March 2015. This amount shall be posted by the Commissioner of Insurance no later than April 1 of each year and shall apply to policies renewed or purchased the following calendar year.

Behavioral Health Services

Behavioral Health Services received from a licensed facility as an inpatient or provided in an outpatient setting are Covered the same as any illness or injury. Covered inpatient services include room and board and professional services furnished by Providers.

Substance Abuse Services

Substance Abuse Services received at licensed facility as an inpatient or provided in an outpatient setting are Covered the same as any illness or injury. Covered inpatient services include room and board and professional services furnished by Providers.

Treatment of the Bones or Joints of the Jaw, Face or Head
Diagnostic, therapeutic or surgical procedures involving bones or joints of the jaw, face or head are Covered on the same basis as any other bone or joint in the body if Medically Necessary for the treatment of a condition that prevents normal functioning of the bone or joint and is caused by congenital deformity, disease or traumatic injury. Covered treatment of conditions involving the temporomandibular joint includes splinting and intraoral prosthetic appliances. Benefits for non-surgical treatment are subject to a lifetime limit of $3,500.

Hearing Aids
For Members under the age of 22 years, one hearing aid per hearing-impaired ear every 36 months is Covered up to two thousand five hundred dollars ($2,500) per hearing aid. This benefit is subject to the same Pre-certification requirements, Deductibles, Coinsurance and Copayments applicable to durable medical equipment. The hearing aids and services must be ordered by a physician or an audiologist licensed in North Carolina. Covered for Members under the age of 22 years are:

- An initial hearing aid per hearing-impaired ear.
- A new hearing aid for the hearing-impaired ear every thirty-six months when alterations to the existing hearing aid cannot adequately meet the needs of the Member.
- Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

Treatment of Teeth and Gums and Special Dental Services
Treatment of the following conditions of the teeth are Covered:

- Injury to sound natural teeth, when treatment is received within 12 months after the injury. Treatment of injuries resulting from eating or chewing are not Covered;
- Functional impairment caused by infection or tumor such as cysts, exostoses and cellulitis; and
- Facility and anesthesia related charges incurred in connection with Dental Services are Covered for children less than 9 years old, persons with serious mental and physical conditions, and persons with serious behavioral problems.

Durable Medical Equipment
Rental or purchase of durable medical equipment is Covered if:

- It is used for the treatment of an injury or sickness, or for the rehabilitation of a malformed body part;
- It is able to withstand repeated use;
- It is for home use; and
- It cannot be used for other purposes.

Rental periods will not exceed 10 months, except for respiratory therapy equipment. After the maximum rental period, the durable medical equipment will belong to the Member.

Repair or replacement of the equipment is Covered unless:

- It is needed as a result of abuse; or
- The equipment was used for purposes for which it was not intended, and
- The repair or replacement is related to routine maintenance, such as the replacement of bulbs or batteries.

Prosthetics/Orthotics other than for positional plagiocephaly; Wig/Scalp Hair Prosthesis
A prosthetic is an artificial device attached to the body to replace a missing part and to aid its function. An orthotic is a support, brace or splint used on the order of a Provider to support, align or correct the function of a moveable part of the body. A wig/scalp hair prosthesis is a wig for patients who have lost their natural scalp hair as a result of chemotherapy for treatment of cancer.

One wig/scalp hair prosthesis is Covered, limited to $350 for one wig per lifetime.

The first purchase of a permanent prosthetic device and a "training" device will be Covered. The first purchase of an orthotic will be Covered. Replacements for prosthetics, orthotics or wig/ scalp hair prosthesis will not be Covered due to loss, theft, or destruction. Replacements needed for prosthetics or orthotics due to growth or normal wear and tear will be Covered, limited to one per calendar year. Prosthetics and orthotics are subject to limitations described in the Schedule of Medical Benefits and may require Pre-Certification.

Prosthetics/Orthotics for positional plagiocephaly
One orthotic device per lifetime is Covered for a Member with positional plagiocephaly.

Ambulance Service
Ground ambulance service is Covered for an Emergency Medical Condition or if otherwise Medically Necessary as Certified by FCC. Air ambulance service is Covered if air transportation from an emergency site to the closest appropriate Hospital is Medically Necessary due to the severity of the Emergency Medical Condition, or if transportation from one Hospital to another one is Medically Necessary due to the unavailability of certain services.

Covered Clinical Trials and Approved Clinical Trials
This section shall not be construed to require benefits for routine patient care services that were not received from Participating Providers.

Covered Clinical Trials are phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that involve the treatment of Life-threatening Conditions, are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives and have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered Clinical Trials must:

- Involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
- 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;
- Be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients; and
- Be provided only to Members who meet the protocol requirements of the Covered Clinical Trial and provide informed consent.

Medically Necessary costs of health care services associated with participation in the Covered Clinical Trial are Covered. Excluded are:

- Health services that are not Medically Necessary;
- Services provided solely to satisfy data collection and analysis needs;
- Expenses for Experimental/Investigational drugs or devices;
- Services not provided for the direct clinical management of the Member;
- Services or supplies supported or funded by national agencies, commercial manufacturers, distributors or other research sponsors of participants in such clinical trials; or
- Non-FDA approved drugs provided or made available to a Member who received the drug during a covered clinical trial after the Member's participation in the covered clinical trial has been discontinued.

In the event a Claim contains charges related to Covered Services, and those charges have not been or cannot be separated from costs for services that are not Covered, FCC may deny the entire Claim.

If the trial does not meet the requirements to be a Covered Clinical Trial, but does meet the requirements for an Approved Clinical Trial, the benefit will be as stated in this paragraph. Routine patient costs (including all items and services consistent with the coverage provided in this Certificate for Members who are not enrolled in any clinical trial) are Covered for Members actually enrolled in an Approved Clinical Trial. As used in this paragraph, the term "routine patient costs" does not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is not Medically Necessary. This section shall not be construed to require benefits for routine patient care services that were not received from Participating Providers.

Reconstructive Breast Surgery
All stages and revisions of reconstructive breast surgery resulting from a mastectomy are Covered. Physical complications in all stages of mastectomy, including lymphedemas, are Covered.

As used in this section, mastectomy means the surgical removal of all or part of a breast as a result of breast cancer or breast disease, as required by law. Please note, reconstructive breast surgery may also be Medically Necessary and Covered for mastectomy resulting from health conditions other than breast cancer or breast disease, such as when needed for accidental injury or certain prophylactic measures. Please contact FCC Member Services for information about FCC's applicable medical policies.

Reconstructive breast surgery means surgery performed as a result of a mastectomy, without regard to the time lapse between the mastectomy and the reconstruction, if the treating Provider so approves, to:

- Reestablish symmetry between the two breasts;
- Reconstruct the mastectomy site;
- Create a new breast mound;
- Reconstruct the nipple and area around it; and
- Reduce or enlarge the non-diseased breast's size.

NOTICE OF WOMEN''S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998, a federal law, the Women''s Health and Cancer Rights Act, became effective. The federal law is similar to a law that previously was passed and then was revised by the North Carolina General Assembly (Coverage for Breast Reconstructive Surgery Resulting from mastectomy). The federal and state laws require group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prosthesis following mastectomies. We are pleased to inform you that your FirstCarolinaCare Insurance Company ("FCC") plan is in compliance with this law.

As the laws require, this notice is to inform Members about the law's provisions. The laws mandate that a Member receiving benefits for a Medically Necessary mastectomy, who elects breast reconstruction after the mastectomy, also will receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the benefit coverage provisions that apply for the mastectomy. If you have questions about coverage of mastectomies and reconstructive surgery, please contact FCC Member Services at (800) 574-8556 or (910) 715-8100.

Diagnosis, Evaluation and Treatment of Lymphedema
FCC will Cover equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education for lymphedema, if determined to be Medically Necessary and provided by a Provider whose treatment of lymphedema is within the Provider's scope of practice.

Covered gradient compression garments must be:

- Prescribed by a Provider;
- Custom-fit for the Member; and
- Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

Bariatric Weight Loss Surgery

FCC will Cover bariatric weight loss surgery when:

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

The benefit limit for Covered bariatric weight loss surgery is listed in the Schedule of Medical Benefits.

Organ and Tissue Transplants

Transplants are Covered only if provided by an FCC-approved transplant center. FCC Covers the following transplants:

- Kidney;
- Heart;
- Lungs;
- Heart-lung together;
- Liver;
- Cornea;
- Pancreas-kidney together; and
- Bone marrow and peripheral stem cell, except those related to high dose chemotherapy for solid tissue tumors.

Covered transplant expenses include:

- Evaluation, screening and candidacy determination process;
- Medical and hospital services provided to a Member and donor during the transplant process;
- Drugs and immunosuppressants;
- Cadaveric and live donor procurement;
- Follow-up care;
- Subject to Pre-Certification and a $5000 maximum benefit per Covered transplant, reasonable travel expenses for the Member recipient and one other person actively involved as a caregiver if the center is more than 60 miles from the recipient's home, including:
    - Transportation to and from the transplant center;
    - Lodging and food;
    - Laundry, telephone, alcohol and tobacco costs are excluded.

If a Member is recommended to receive an organ or tissue transplant, the Member or his/her physician must contact FCC for Pre-certification prior to transplant evaluation. The UNC Health Care System is FCC's exclusive transplant center for kidney, pancreas, pancreas/kidney, liver, lung, heart, heart/lung and certain bone-marrow/stem cell transplants. These transplants will be Covered only if they are provided by the UNC Health Care System. However, if UNC Health Care does not accept the Member as a candidate after evaluation, cannot accommodate a suitable candidate for other reasons or if the Member needs a transplant that is not performed by UNC Health Care, then the Member will be referred to a transplant center that participates in an approved national transplant network, taking into account Member needs and the most appropriate setting for the procedure. Please note that each transplant center makes its own determination whether the Member meets its medical criteria for transplantation.

Experimental/Investigational transplants are not Covered, except as stated under Covered Clinical Trials and Approved Clinical Trials. Services for other than human organ and tissue transplants are not

Covered.

Reconstructive Surgery (not including Reconstructive Breast Surgery)
Covered Services are limited to surgery to correct:

- A functional defect that results from a birth defect; or
- A seriously disfiguring condition resulting from injury.

Hospice Services
Covered Services include those customarily provided by a Provider in the home for care and support of a terminally ill Member with a life expectancy of 6 months or less.

Prescription Drugs
The following coverage conditions apply to Prescription Drug benefits:

- Member costs for each Prescription Order or Refill and applicable supply limits are listed on the Schedule of Medical Benefits. Initial Prescription Orders and Refills may be subject to supply limits, which may be waived in the event of a declared emergency or disaster.

- When, the Member (through the Member's prescriber) follows the exception process indicating that a non-preferred Prescription Contraceptive Drug or Device is Medically Necessary for the Member, the Member will have no additional cost-sharing for that non-preferred Prescription Contraceptive Drug or Device. The Member should call the number on her ID card to begin this exception request. When, for any other reason, a Member receives a Brand Name Drug for which a Generic Drug equivalent exists, the Member must pay:

    - the difference in price between the Brand Name Drug and the Generic Drug; and
    - the Copayment for the Brand Name Drug.

- A prescription for a Narrow Therapeutic Index Drug, as defined in NCGS §90-85.27, shall be refilled using only the drug product by the same manufacturer that the pharmacist last dispensed under the Prescription Order, unless the prescriber is notified by the pharmacist prior to the dispensing of another manufacturer's product, and the prescriber and the Member give documented consent to the dispensing of the other manufacturer's product. The term "refilled" shall include a new Prescription Order written at the expiration of a prescription that continues the Member's therapy on a Narrow Therapeutic Index Drug. The Copayment that applies to the dispensed Prescription Drug must be paid by the Member.

- Failure to obtain Prior Authorization when required will result in the Prescription Drug not being Covered.

- FCC will Cover a Restricted Access Drug or Device without requiring use of an unrestricted medication or device if the Member's Provider certifies in writing that the Member previously used an alternative unrestricted drug or device and it was detrimental to the Member's health or ineffective in treating the same condition, and in the opinion of the treating Provider, is likely to be detrimental to the Member's health or ineffective in treating the condition again.

Upon request, a Provider, pharmacist or Member may receive a copy of a summary Formulary. The Formulary describes preferred Prescription Drugs.

The list of Prescription Drugs requiring Prior Authorization is subject to periodic review and modification by FCC. The Member may obtain a list of Prescription Drugs requiring Prior Authorization by calling FCC or on the FCC webpage.

For certain Prescription Drugs prescribed on and after August 1, 2016 for chronic illness, FCC will allow synchronization. If the following conditions apply, FCC will apply a prorated daily cost-sharing rate to any Prescription Drug dispensed by a pharmacy that is a Participating Provider, except that any dispensing fee shall not be prorated and shall be based on an individual Prescription Drug filled or refilled. Synchronization will apply if it is agreed among the Member, the Provider, and a pharmacist that is a Participating Provider that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the Member for the management or treatment of that chronic illness, and all of the following apply:

(1) The medications are covered by the clinical coverage policy.
(2) The medications are used for treatment and management of chronic conditions, and the medications are subject to refills.
(3) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.
(4) The medications meet all Prior Authorization criteria specific to the medications at the time of the synchronization request.
(5) The medications are of a formulation that can be effectively split over required short-fill periods to achieve synchronization.
(6) The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

For information on how to request synchronization of a Prescription Drug, the Member should contact the Pharmacy Help Desk at 800-788-2949.

The following services or items are not Covered:

- Prescribed Drugs or devices that are used to terminate a pregnancy unless necessary to preserve the life or health of the mother. Prescription Drugs or devices subject to this exclusion shall include but are not limited to: Mifeprex or any equivalent drug product.

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- Over-the-counter drugs and supplies, except as specified by FCC. Certain over-the-counter drugs which are used for preventive care are covered if the Member has a prescription. This includes, for example, aspirin and iron supplements. For a list of the preventive care drugs covered by this provision, contact Member Services.

- Prescription Orders or Refills required because of theft or loss.

- Prescription Drugs deemed to be abused or misused by a Member.

- Prescription Orders or Refills exceeding supply limitations, except under certain circumstances under a state of emergency or disaster.

- Prescription Drugs prescribed for the treatment of Dental Services, except for an injury to sound, natural teeth.

- Any Prescription Drug dispensed by a Provider or provided to a Member upon discharge from a Hospital or other facility.

- Medications for cosmetic purposes and weight loss.

- Growth hormone therapy unless prescribed for a congenital defect/ anomaly; idiopathic short stature or constitutional delayed growth is not a congenital defect/ anomaly.

- Compounded medications.

- Prescription Drugs or non-Prescription Drugs dispensed by a Provider's office or other outpatient facility.

- Medications used for fertility purposes

- Medical foods

Appeal and Grievance Procedures Applicable to Prescription Drug Claims

If a Member does not agree with a Noncertification involving a Prescription Drug, the decision may be appealed. Members have 180 days after the Member received the adverse decision to request an Appeal. All Appeals will be evaluated by a Physician licensed to practice in North Carolina who was not involved in the Noncertification.

The Member (or a person acting on the Member's behalf) must write a letter to MedImpact, FCC's pharmacy benefit manager, to initiate an Appeal regarding services that are not needed on an expedited basis. The letter must be sent to:

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

Within 3 business days after getting the written request for an Appeal, MedImpact will provide the name and telephone number of the Appeals and Grievance Coordinator. The Member will also get instructions for submitting written material for review. FCC will send a written decision within 30 days after the date FCC receives the Appeal.

Expedited Prescription Drug Appeals

Members have the right to a more rapid or expedited Appeal of an adverse decision if following the standard time limits would:

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

The Member may call MedImpact at 800-788-2949 to verbally request an expedited Appeal.

For most expedited Appeals, a decision will be made within 72 hours of receiving the Appeal. If the service is related to an ongoing treatment, the Member will be given a decision, after consulting with a medical doctor, within 24 hours of receipt of the Appeal, if the care will not be completed within 24 hours. Expedited Appeals are not available in cases where the Member has already received services.

If the Member does not agree with FCC's decision on any Appeal, he/she can ask for the decision to be reviewed again. This is known as a second level Grievance. The second level Grievance procedure is described below.

First Level Grievance

A Member or someone acting on the Member's behalf may submit a Grievance (refer to definition of Grievance on page 5 for examples).

All Grievances should be in writing and provide all details about the Grievance, including the date of the event, place and people involved. Mail to:

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

Within 3 business days after receiving a Grievance, the Member will be provided the name and telephone number of the appeals and grievance coordinator. The Member will also get instructions for submitting written material for the first level Grievance review. Written material relating to the Grievance may be submitted to the Appeals and Grievance Coordinator. There is no right to attend the first level Grievance review.

A written decision will be sent within 30 days of the date of receiving the first level Grievance. The decision will include reason(s) for denial if the decision is not in the Member's favor and will also include instructions on what to do if a further review is desired.

Second Level Grievance

The Member or someone acting on his/her behalf may request second level review of a decision not in the Member's favor on an Appeal of a Noncertification.

The Member or his/her representative must send a written request for a second level Grievance review. This request must be made within 30 days of receiving the first level decision. A request can be made to:

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

Within 10 business days, the Member will be sent the name and telephone number of the appeals and grievance coordinator and a statement of Member rights related to the Grievance process. These include the right:

- To ask and get all information important to the review;
- To explain his/her position to the second level review panel;
- To submit supporting material prior to and at the review meeting;
- To ask questions of any member of the review panel;
- To be helped or represented by a person of the Member's choosing, including a family member, Employer representative or lawyer; and
- To participate in the second level Grievance review via telephone conference.

The review panel will hold a review meeting within 45 days after receiving the review request. The Member will be told the meeting date at least 15 days before the meeting. The Member does not have to attend the review meeting in order to receive a full and fair review. Within 7 business days after it meets, the Member will receive a letter describing the second level review panel's decision.

A Member may ask for the second level review to take place on a faster schedule. A faster schedule is available if the time frames described above seriously put life or health at risk or put a Member's ability to regain maximum function at risk. An expedited second level review is available whether or not the initial review of the Appeal was done on a faster schedule. The review will be done and the decision given within 4 days after receiving all necessary information. The review meeting may take place by telephone call or through the exchange of written information.

This procedure, (including the second level grievance available after an Appeal of a Noncertification) is voluntary for Members.

Members may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, toll free telephone: (855) 408-1212, for information about state laws regarding appeals and grievances.

Members also may contact Health Insurance Smart NC as follows:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
http://www.ncdoi.com/smart

In Person:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart
Toll Free Telephone: (855) 408-1212

A description of Member's right to request an external review begins on page 36.

Other Services
Services other than those described under "Covered Services" may be Covered in some cases. The Member, his/her Provider or FCC may recommend such a service. FCC will Cover the service if the following conditions are met:

- The service is approved by FCC's Medical Management Program as a safer and more cost-effective treatment than what would otherwise be provided;
- Pre-certification is given prior to the services being provided; and
- The treatment is agreed to by the Member and the Member's attending Provider.

EXCLUSIONS AND LIMITATIONS

The following services, items, and supplies are not Covered by FCC:

1. Treatment, services or supplies for an injury or sickness as a result of war or an act of war, declared, or undeclared. This includes the treatment of disabilities, diseases or injuries resulting from military service.

2. Services, treatment or supplies if no charge would have been made if the Member did not have this coverage. This includes services, treatment or supplies received from a person who normally lives in the Member's household or is a member of his/her immediate family (closely related, such as parent, grandparent, sibling, child).

3. Health services for injury received while a Member is engaged in an act that has been prosecuted or may be prosecuted as a misdemeanor or felony by an appropriate law enforcement agency.

4. Custodial Care.

5. Services, treatment or supplies in a facility, or part of a facility, that is mainly a place for (a) rest, residence or assisted living; (b) convalescence; (c) Custodial Care; (d) the aged; or (e) training or schooling. This exclusion includes, but is not limited to, charges for residential treatment centers (by whatever name). This exclusion does not apply to services that meet the terms and conditions described under "General Coverage Rules," which will be Covered Services under the same terms and conditions as would apply if the Member were residing in a private living space.

6. Experimental/Investigational treatment, services, drugs or supplies, including any related diagnostic services, exams or supplies and regardless of the applicable sickness or injury. This exclusion does not apply to services for which benefits are available under this Certificate for a Covered Clinical Trial or an Approved Clinical Trial.

7. Purchase or fitting of glasses or contact lenses, except for one pair immediately following cataract surgery, unless the Employer purchased a Vision Rider to be included with this Certificate.

8. Routine eye exams or other routine eye services, vision screenings or tests unless the Employer purchased a Vision Rider to be included with this Certificate. This exclusion does not apply to one routine annual eye exam for Members with a medical diagnosis of diabetes.

9. Radial keratotomy, myoptic keratomileusis, and any surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia or stigmatic error.

10. Dental Services, except those specifically listed as Covered in "Covered Services", including but not limited to services related to dentures, orthodontia, crowns, bridges, periodontal disease, root canals, dental root form implants and oral surgery.

11. Services, treatment or supplies for obesity, weight reduction or weight control, except surgery that meets the requirements for "Bariatric Weight Loss Surgery" under "Covered Services."

12. Services, treatment or supplies for weak, strained or flat feet, or instability or imbalance of the feet, including orthopedic shoes or other supportive devices.

13. Cutting, removal or treatment of corns, calluses or toe nails. This exclusion does not apply to routine foot care for Members with a medical diagnosis of diabetes.

14. Services, treatment or supplies for complications related to or arising from treatment or an operation to improve appearance if the original treatment or operation either was not a Covered Service or would not have been a Covered Service if the individual had been a Member.

15. Cosmetic services. This includes any surgery done primarily to improve the appearance of any part of the body and not to improve physical function. Some examples are:
    - surgery for sagging or extra skin;
    - any enlargement or reduction procedures;
    - rhinoplasty and associated surgery; and
    - any procedures utilizing an implant that does not change physical function or is not incident to a surgical procedure.

    This exclusion does not apply to reconstructive surgery following an injury or to correct a congenital defect for newborn, adoptive and foster children.

16. Services, treatment or supplies designed to alter physical characteristics of the Member to those of the opposite sex, and any other care (including but not limited to psychotherapy) or studies related to sex changes.

17. Services, treatment or supplies related to sexual deviation, including services, treatment or supplies for sexual dysfunction unless related to organic disease.

18. Maternity benefits for Eligible Dependents other than spouses. Complications of Pregnancy are Covered for all Members.

19. Private duty nursing.

20. Services, treatment or supplies for infertility such as artificial insemination or an implant procedure to induce pregnancy, in vitro fertilization, fertility drugs, sonograms or other fertility procedures.

21. Reversal of surgical sterilization.

22. Genetic testing. This exclusion does not apply to genetic testing listed as a Covered Service under either the “Imaging and Laboratory Services,” “Women’s Health” or the “Maternity Care” section.

23. Biofeedback, environmental therapy, acupuncture, acupressure, massage therapy, herbal, nutritional and hypnotherapy services.

24. The replacement of an initial prosthesis due to loss, theft, or destruction, not including the trainer temporary prosthesis.

25. Services, treatment or supplies for mental retardation, behavioral developmental delay disorders or learning disabilities except limited diagnostics and education expressly listed under "Covered Services."

26. Services or supplies for the treatment of an occupational injury or sickness that are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

27. Personal convenience items that are not directly related to Covered Services. Examples of excluded items include telephone, television or the rental of such items whether in an inpatient, outpatient or home setting; air conditioners, humidifiers, dehumidifiers and air purifiers; exercise equipment, arch support or orthotics used for participation in sports.

28. Abortion, unless the life of the mother would be endangered by carrying the fetus to term.

29. Any medical, psychological or psychiatric services, treatment or supplies that are the result of a court order or required by a third party, unless Medically Necessary or required by a Qualified Medical Child Support Order.

30. Any nutritional substance, whether in liquid or solid form, including any supplement, infant formula, non-infant nutrition formula or meal replacement product, regardless of whether or not the substance is administered orally or through a feeding tube. This exclusion applies to

megavitamin regimens and orthomolecular therapy. This exclusion does not apply to total parenteral nutrition delivered in accordance with the General Coverage Rules.

31. Premarital laboratory work required by any state or local law.

32. Charges for medical reports or for the completion of forms unless requested by FCC.

33. Examinations for obtaining or maintaining employment, insurance, professional, or other licenses, school exams and sports physicals.

34. Appearances at hearings and court proceedings by a Provider.

35. Immunizations for international travel.

36. Travel and transportation expenses. Travel and transportation expenses related to transplants may be Covered when Certified by FCC.

37. Sclerotherapy (injection of sclerosing solutions) for the treatment of varicose veins for cosmetic reasons.

38. Charges for missed or canceled appointments.

39. Any service, supply or treatment for which a chelating agent is used except for the treatment of heavy metal poisoning.

40. Any service, supply or treatment in excess of any applicable limit or maximum as stated in this Certificate or in the Schedule of Medical Benefits.

41. Covered Services for which payment has been made under Medicare or any other federal, state or local government program (excluding Medicaid).

42. Medical or surgical complications resulting from a non-Covered service, except for Emergency Medical Services.

43. Extra charges above the usual fee for obtaining, storing or administering donated blood. This includes a Member arranging for blood donations to be used by the Member at a future time.

44. Hearing exams, tests, hearing aids and other routine hearing care services, treatments and supplies. This exclusion does not apply to Covered hearing exams for newborns and children under the age of 17 and coverage for hearing aids for Members under 22 years of age as described under “Hearing Aids” in the Covered Services section.

45. Purchase or fitting of corrective shoes, devices, or appliances except orthotics as specifically stated under Covered Services.

46. Services, treatment or supplies received more than 180 days prior to submission of a Claim to FCC unless it was not reasonably possible for the Claim to be filed within the 180 day period. In such case, Claim must be filed as soon as reasonably possible but in no case later than 1 year from the time submittal of the Claim is otherwise required, except in the absence of legal capacity of the Member. The 1 year extension, if applicable, does not require FCC to make payments to Participating Providers whose contracts allow a shorter period in which to file claims. However, the 1 year extension stated in this paragraph will be applied to any claims filed by Members for Covered Services rendered by Non-Participating Providers.

47. Services, treatment or supplies for which the Member has no financial obligation or where he/she is not required to pay Coinsurances, Deductibles or Copayments.

48. The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.

49. Services, treatment or supplies received from the Member's close relative or a person living in the Member's household.

50. Donor eggs and sperm; services received by an organ donor if not a Member.

51. Surrogate mothers.

52. Treatment for infertility or reduced fertility that results from a prior procedure resulting in sterilization or a normal physiological change such as menopause.

53. Counseling with relatives about a patient.

54. Inpatient confinements that are primarily intended as a change of environment.

55. Group therapy for Pulmonary Rehabilitation.

56. Wigs, hair replacement, hair prosthesis, cranial prosthesis; hair implants or hair plugs; except one wig/ scalp hair prosthesis per lifetime for hair loss due to chemotherapy for cancer with the limits as specifically noted under Covered Services.

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

MEDICAL MANAGEMENT

Medical Management Program

FCC's Medical Management Program is designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, Providers or facilities. In issuing a decision, FCC shall obtain all information required to make the decision, including pertinent clinical information; FCC will limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care service.

Procedures For Pre-certification

Pre-Certification is the main tool used in FCC's Medical Management Program. A current list of services and items that require Pre-certification is included with this Certificate as Attachment A.

Members are responsible for getting any required Pre-certification before receiving services. Providers usually will help with getting a Pre-certification. Pre-certification can be requested by calling the toll-free number on the FCC ID card or faxing a request to FCC. This must be done before starting any treatment so that FCC will have time to make a decision or get more information if needed. The request must include:

- Member name;
- Member ID number;
- The name and address of any Hospital or Provider to be used; and
- Treating Provider's name.

Important Note: An additional 20% Coinsurance penalty will be applied to Claims when FCC's Certification requirements are not met. The amount of this penalty does not count toward any Out-of-

Pocket Maximum. FCC will not make any payment for services for which a Noncertification is issued.

No Pre-certification is needed for Emergency Services.

No Pre-certification is needed for the routine Maternity Care Services for mother and baby described above under "Covered Services". Pre-certification is needed for services that extend beyond the routine maternity services described above.

Procedures For Certification
FCC may make a Certification decision during a Member's hospital stay or course of treatment (including requests for an extension of the course of treatment beyond the Certified period of time). FCC must provide benefits for such services until the Member gets a mailed, faxed, or other written notice of Noncertification regarding the services.

FCC shall notify the Member of the Certification decision (whether adverse or not) within 3 days after receipt of the Claim, unless the request is for Emergency Medical Services. Notification will be consistent with North Carolina law and FCC's policies and procedures.

This period may be extended one time for up to 15 days if additional time is required due to a failure of the Member to submit information necessary to make the Certification decision. FCC will give the Member a Notice of Extension. The Notice of Extension will describe the additional information requested. The Member may have at least 45 days from receipt of the Notice of Extension to provide the specified information. FCC will then give a decision to the Provider and Member within 3 business days after the earlier of (a) the date FCC received the necessary information; or (b) the end of the period given to the Member to provide the information.

For Certifications requested after the Member receives health services, the Member will be notified of the decision within a reasonable period of time, but not later than 30 days after FCC's receipt of the request. This period may be extended one time by FCC for up to 30 days if additional time is required because the Member did not submit information necessary to decide the request. FCC will give the Member a Notice of Extension. The Notice of Extension will describe the necessary information and the Member may have at least 90 days from receipt of the notice to provide the necessary information. FCC will then give a decision to Member within thirty days after the earlier of (a) the date FCC received the information or (b) the end of the period given to the Member to provide the information.

Pre-certifications and Certifications are used only to determine benefits. They are not medical advice and do not determine the Member's eligibility or enrollment. Payment, enrollment and amount of benefits are subject to all the terms of this Certificate and the Master Employer Agreement. A Pre-certification or Certification may be retracted only if the determination was based on a material misrepresentation about a health condition that was knowingly made by a Member or Provider of the service, supply, or other item. Any requests for information made to members by FCC will be limited to the information necessary to make a decision on a Pre-certification or Certification.

Expedited Pre-certifications and Certifications
Members have the right to a more rapid or expedited decision on a Pre-certification or Certification request if following the standard time limits would:

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

In these cases, FCC will give the Member a decision (whether adverse or not) as soon as possible,

taking into account the medical situation, but not later than 72 hours after FCC received the request unless the Member fails to provide necessary information.

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

For an expedited Certification extending services already Certified, the decision will be made as soon as possible, considering the medical situation. FCC will notify the Member of the Certification decision within 24 hours after the receipt of the request by FCC. Such requests must be made to FCC within 24 hours prior to the end of the Certified time or services.

The notice of a denial of an expedited Certification or Pre-certification may be oral. However, written notice must be provided to the Member no later than 3 days after the oral notice.

If a Member does not agree with an FCC decision denying a Certification or Pre-certification, an appeals procedure is available. It is described in the section titled "Appeals and Grievance Procedure."

COMPLAINTS, APPEALS AND GRIEVANCE PROCEDURES

Quality of Care Complaints

Complaints about the quality of a Provider's care, service or service problems with a Provider are not considered Appeals or Grievances and are handled separately.

For complaints concerning the quality of clinical care or level of services delivered by a Provider, FCC will acknowledge the complaint in writing within 10 business days after receiving it. This letter will advise the Member that FCC will refer the complaint to FCC's quality assessment committee for review and consideration or any appropriate action against the Provider. North Carolina law does not allow for a second level of review for complaints concerning quality of care.

Standard Appeals

If a Member does not agree with a decision to deny Certification or Pre-certification of a medical service, the decision may be appealed. Members have 180 days after the Member received the decision to request an Appeal of the denial of Certification or Pre-certification. All Appeals will be evaluated by a Physician licensed to practice in North Carolina who was not involved in the Noncertification.

The Member (or a person acting on the Member's behalf) must write a letter to FCC to initiate an Appeal regarding services that are not needed on an expedited basis. The letter must be sent to:

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

Within 3 business days after getting the written request for an Appeal, FCC will provide the name and telephone number of the Appeals and Grievance Coordinator. The Member will also get instructions for submitting written material for review. FCC will send a written decision within 30 days after the date FCC receives the Appeal.

Expedited Appeals
Members have the right to a more rapid or expedited Appeal of a Pre-certification or Certification decision if following the standard time limits would:

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

The Member may call FCC at 910-715-8100 to verbally request an expedited Appeal.

For most expedited Appeals, FCC must give the Member a decision within 72 hours of FCC receiving the Appeal. If the service is related to an ongoing treatment, FCC must give the Member a decision, after consulting with a medical doctor, within 24 hours of FCC receiving the Appeal, if the care will not be completed within 24 hours.

Expedited Appeals are not available in cases where the Member has already received services.

The Member may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, or by telephone at (855) 408-1212 for information about state laws regarding appeals.

Members also may contact Health Insurance Smart NC:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
http://ncdoi.com/smart

In Person:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart
Toll Free Telephone: (855) 408-1212

If the Member does not agree with FCC's decision on any Appeal, he/she can ask for the decision to be reviewed again. This is known as a second level Grievance. The second level Grievance procedure is described below.

Grievance Procedures

First Level Grievance
A Member or someone acting on the Member's behalf may submit a Grievance (refer to definition of Grievance for examples).

All Grievances should be in writing and provide all details about the Grievance, including the date of the event, place and people involved. Mail to:

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

Within 3 business days after FCC gets a Grievance, FCC will provide the name and telephone number of the appeals and grievance coordinator. The Member will also get instructions for submitting written material for the first level Grievance review. Written material relating to the Grievance may be submitted to FCC. There is no right to attend the first level Grievance review.

FCC will send a written decision within 30 days of the date on which FCC receives the first level Grievance. The decision will include reason(s) for denial if the decision is not in the Member's favor and will also include instructions on what to do if a further review is desired.

Second Level Grievance

The Member or someone acting on his/her behalf may request second level review of (1) a decision not in the Member's favor from the first level Grievance review and (2) a decision not in the Member's favor on an Appeal of a Noncertification.

The Member or his/her representative must send a written request for a second level Grievance review. This request must be made within 30 days of receiving the first level decision. This written request must be sent to:

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

After FCC gets the second level review request, FCC will send important information within 10 business days. This information will include the name and telephone number of the appeals and grievance coordinator and a statement of Member rights related to the Grievance process. These include the right:

- To ask and get from FCC all information important to the review;
- To explain his/her position to the second level review panel;
- To submit supporting material prior to and at the review meeting;
- To ask questions of any member of the review panel;
- To be helped or represented by a person of the Member's choosing, including a family member, Employer representative or lawyer; and
- To participate in the second level Grievance review via telephone conference.

The review panel will hold a review meeting within 45 days after receiving the review request. The Member will be told the meeting date at least 15 days before the meeting. The Member does not have to attend the review meeting in order to receive a full and fair review. Within 7 business days after it meets, the Member will receive a letter describing the second level review panel's decision.

A Member may ask for the second level review to take place on a faster schedule. A faster schedule is available if the time frames described above seriously put life or health at risk or put a Member's ability to regain maximum function at risk. An expedited second level review is available whether or not the initial review of the Appeal was done on a faster schedule. FCC will do the review and give the decision within 4 days after receiving all necessary information. The review meeting may take place by telephone call or through the exchange of written information.

FCC's Grievance procedure, (including the second level grievance available after an Appeal of a Noncertification) is voluntary for Members.

Legal Actions. No action at law or in equity may be brought to recover on the policy prior to expiration of 60 days after written proof of loss has been furnished. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

The Member may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, or by telephone at (855) 408-1212 for information about state laws regarding grievances.

Members also may contact Health Insurance Smart NC:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
http://www.ncdoi.com/smart

In Person:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart
Toll Free Telephone: (855) 408-1212

Members who are eligible for FCC benefits through an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) have the right to bring a civil action under section 502(2) of ERISA following an adverse decision on appeal.

External Review

In General

In addition to FCC's Appeals and Grievance Procedures, North Carolina law provides for review of Noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this voluntary service at no charge to the public. The Member or his/her representative may request an external review. The IRO's external review decision is binding on FCC and the Member, except to the extent other remedies are available under applicable federal or state law. The Member may not file a subsequent request for an external review involving the same Noncertification decision for which a Member has already received an external review decision.

FCC will notify the Member in writing of the right to request an external review at the time of receiving:

- A Noncertification decision,
- An Appeal decision upholding a Noncertification decision, or
- A second level Grievance review decision upholding the original Noncertification.

Eligibility

In order for a Member to be eligible for external review, the NCDOI must determine the following:

- That the request is about a medical necessity determination that resulted in a Noncertification decision,
- That the Member had coverage with FCC in effect when the Noncertification decision was issued,

- That the service for which the Noncertification was issued appears to be a Covered Service under the Certificate, and
- That FCC's internal review process have been exhausted as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, the internal review process is exhausted when a Member has:
- Completed FCC's Appeal and second level Grievance review and received a written second level determination from FCC, or
- Filed a second level Grievance and unless the Member requested or agreed to a delay, have not received FCC's written decision within 60 days of the date the Member can demonstrate that the Grievance was submitted, or
- Received notification that FCC has agreed to waive the requirement to exhaust the internal Appeal and/or second level Grievance process.

If the request for a standard external review is related to a retrospective Noncertification (a Noncertification that occurs after services have been received), the Member will not be eligible to request a standard review until completing FCC's internal review process and received a written final determination from FCC.

Standard External Review
If a Member wishes to request a standard external review, he/she (or a representative) must make this request to NCDOI within 120 days of receiving FCC's written notice of final determination that the services in question are not Certified. When processing the request for external review, the NCDOI will require a written, signed authorization for the release of any medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of the request for a standard external review, the NCDOI will notify the Member and his/her Provider of whether the request is complete and whether it is accepted. If the NCDOI notifies a Member that the request is incomplete, the Member must provide all requested additional information to the NCDOI within 150 days of the date of FCC's written notice of final determination. If the NCDOI accepts the request, the acceptance notice will include:
- The name and contact information for the independent review organization (IRO) assigned to the Member's case,
- A copy of the information about his/her case that FCC has provided to the NCDOI,
- Notice that FCC will provide you with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO), and
- Notification that additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO may be accepted within 7 days of the date of the acceptance notice.

If the Member chooses to provide any additional information to the IRO, he/she must also provide that same information to FCC at the same time using the same means of communication (e.g., fax the information to FCC if faxed it to the IRO). When faxing information to FCC, it must be sent to 910-715-8102 or toll-free at 866-896-1941. For mail, the address is:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

Please note that a Member may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and FCC. The NCDOI will forward this information to the IRO and FCC within two business days of receiving the additional information.

The IRO will send written notice of its determination within 45 days of the date the NCDOI received the standard external review request. If the IRO's decision is to reverse the Noncertification, FCC will reverse the Noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the Noncertification decision. If the Member is no longer enrolled in FCC at the time FCC receives notice of the IRO's decision to reverse the Noncertification, FCC will only provide coverage for those services or supplies actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

Expedited External Review

An expedited external review of a Noncertification decision may be available if the Member has a medical condition where the time required to complete either an expedited internal appeal or second-level grievance review or a standard external review would reasonably be expected to seriously jeopardize life or health or would jeopardize the ability to regain maximum function. If the Member meets this requirement, he/she may make a written request to the NCDOI for an expedited review after the Member:

- Receives a Noncertification decision from FCC AND file a request with FCC for an expedited appeal, or
- Receives an appeal decision upholding a Noncertification decision AND file a request with FCC for an expedited second level grievance review, or
- Receives a second-level grievance review decision upholding the original Noncertification.

The Member may also make a request for an expedited external review if he/she receives an adverse second-level grievance review decision concerning a Noncertification of an admission, availability of care, continued stay or Emergency Services, but has not been discharged by the Provider.

In consultation with a medical professional, the NCDOI will review the request and determine whether it qualifies for expedited review. The Member and the Provider will be notified by the NCDOI within 2 days if the request is accepted for expedited external review. If the request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard External Review if FCC's internal review process was already completed, or (2) require the completion of FCC's internal review process before the Member may make another request for an External Review with the NCDOI. An expedited external review is not available for retrospective Noncertifications.

As soon as possible, but within the same day after FCC receives notice that the request has been assigned to a review organization, FCC or its designee utilization review organization shall provide or transmit all documents and information considered in making the Noncertification appeal decision or the second-level grievance review decision to the assigned review organization electronically or by telephone or facsimile or any other available expeditious method. A copy of the same information shall be sent by the same means or other expeditious means to the Member or the Member’s representative who made the request for expedited external review.

The IRO will communicate its decision within 3 days after receipt of the request for an expedited external review. If the IRO's decision is to reverse the Noncertification, FCC will, within one day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply. If the Member is no longer enrolled in FCC at the time FCC receives notice of the IRO's decision to reverse the Noncertification, FCC will only provide coverage for those services or supplies actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

Additional Resources:
The Member may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, or by telephone at (855) 408-1212 for information about state laws regarding utilization review and internal appeals and grievance issues.

Members also may contact Health Insurance Smart NC:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201

Toll Free Telephone: (855) 408-1212
http://www.ncdoi.com/smart

In Person:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart

HOW TO CLAIM BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PARTICIPATING PROVIDERS

Participating Providers will submit Claims to FCC on the Member's behalf. Non-Participating Providers may require payment at the time of service and the Member may be responsible for filing the Claim. When submitting a Claim for services provided by a Non-Participating Provider, Members must also submit copies of bills for all charges. Except as described below under "Assignment of Benefits", these benefits may be paid directly to the Provider. Claim forms may be obtained from FCC or the Employer and all required fields must be completed, including but not limited to, the Provider's National Provider Identifier ("NPI") issued by the National Plan and Provider Enumeration System.

The Member or the Provider must send the Claim to reach FCC within 180 days after the date of service. Services for which a Claim and written proof of all expenses is not received by FCC within 180 days after the date of service will not be a Covered Service unless it was not reasonably possible for the Claim to be filed within the 180 day period. In such case, the Claim must be filed as soon as reasonably possible but in no case later than one (1) year from the time submittal of the Claim is otherwise required, except in the absence of legal capacity of the Member. The 1 year extension, if applicable, does not apply to Participating Providers whose contracts allow a shorter period in which to file Claims. However, the 1 year extension stated in this paragraph will be applied to any Claims filed by Members for Covered Services rendered by Non-Participating Providers.

PLEASE MAIL PAPER COMPLETED CLAIMS TO:
FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

Electronic claims may be sent by the Provider to FCC at the address indicated on the FCC website.

FCC may, from time to time, identify certain Non-Participating Providers to which a Member cannot assign benefits under this Certificate. The Employer will be given a written list of such Providers on request. If a Member receives Covered Services from these Providers, FCC will issue payment to the

Member rather than to the Provider, even if a Member has authorized benefits to be assigned to the Provider.

COORDINATION OF BENEFITS

Order of Payment

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

- The plan covering a person as an employee is primary.
- The plan covering a person as a spouse is secondary.
- The plan covering a child as a dependent of the parent whose birth date falls first during the year is primary.
- If both parents have the same birth date, the plan that has covered a parent for the longer period of time will be primary.
- If the parents are divorced or separated, the plan that covers the child as a dependent of the parent with custody is primary.
    - The plan that covers the child as a dependent of the spouse of the parent with custody is primary to-
    - The plan that covers the child as a dependent of the parent without custody.
- If there is a court order that requires a parent to purchase the child's health coverage and FCC has knowledge of the court order, then that plan will be primary.
- A plan that covers a person other than as a laid-off or retired employee or as a dependent of other than a laid-off or retired employee is primary to a plan that covers the person as a laid-off or retired employee (unless this results in a conflict in determining order of benefits).
- If none of the above rules apply, the plan that has covered a person the longest is primary.
- If the other plan does not have rules that establish the same order of benefits as FCC, then that plan will be primary.

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

Facility Of Payment

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

Right Of Recovery

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

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

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

Coordination With Medicare

Special rules may apply if a Member is eligible for Medicare. Benefits will be paid according to Medicare rules and will not exceed the Medicare allowable.

CONTINUATION OF COVERAGE AND CONVERSION COVERAGE

Generally

If disenrolled due to loss of employment or if other "qualifying events" occur, a Subscriber and any Eligible Dependents may be entitled to:

- Continuation coverage under federal or state law; or
- Conversion coverage.

These types of coverage are explained in the sections that follow.

Continuation Coverage

Continuation coverage is group health coverage that may be continued under federal or state law under specified terms and conditions when certain qualifying events occur. The Employer is responsible for determining if Members are eligible to continue health coverage under either state or federal law, described below.

Continuation Coverage under Federal Law

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

The Employer is responsible for administering COBRA continuation coverage, but it may elect to delegate that responsibility to another entity. Most Employers designate FCC to act as the COBRA administrator, but that is not always the case. The Member should contact the Employer to confirm who is responsible for COBRA administration. The remainder of this discussion assumes that the Employer has designated FCC to act as the COBRA administrator. If FCC is not the COBRA administrator, certain information regarding your right to COBRA continuation coverage may change, including the contact information for the COBRA administrator and the procedures for providing notice of certain events.

The contact information for FCC is:

FirstCarolinaCare Insurance Company
Attn: COBRA Administrator
42 Memorial Drive
Pinehurst, NC 28374
Phone: 910-715-8100
Fax: 910-715-8101

This section contains important information about the right to COBRA continuation coverage under the group health plan described in this Certificate (the "Health Plan"). What follows explains COBRA continuation coverage, when it may be available and what to do to protect the right to receive it.

COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Health Plan because of a qualifying event. The Subscriber and Eligible Dependents could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

In addition to COBRA continuation coverage, a qualified beneficiary may have other options available when he/she loses group health coverage. For example, a qualified beneficiary may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the

Marketplace, the qualified beneficiary may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, a qualified beneficiary may qualify for a 30-day special enrollment period for another group health plan for which he/she is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additional information is provided below.

When COBRA Continuation Coverage is Available

A Subscriber will become a qualified beneficiary if he/she loses coverage under the Health Plan because either one of the following qualifying events happens:

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

A spouse of a Subscriber can become a qualified beneficiary if he/she loses coverage under the Health Plan because any one of the following qualifying events occurs::

- The Subscriber dies;
- The Subscriber's hours of employment are reduced;
- The Subscriber's employment ends for any reason other than gross misconduct;
- The Subscriber becomes entitled to Medicare benefits (under Part A or B or both); or
- The spouse is divorced or legally separated from the Subscriber.

Also, if a Subscriber reduces or eliminates his/ her spouse's coverage under the Health Plan in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for the spouse even though his/her coverage was reduced or eliminated before the divorce.

Other Dependents can become qualified beneficiaries if they lose coverage under the Health Plan because any one of the following qualifying events occurs:

- The Subscriber parent dies;
- The Subscriber parent's hours of employment are reduced;
- The Subscriber parent's employment ends for any reason other than gross misconduct;
- The Subscriber parent becomes entitled to Medicare benefits (under Part A or B or both);
- The Subscriber and spouse are divorced or legally separated; or
- The dependent stops being an Eligible Dependent.

Children born to or placed for adoption with a Subscriber during the continuation coverage period may also elect continuation coverage, as long as the Subscriber has elected COBRA coverage for himself or herself. The coverage period will be determined according to the date of the qualifying event that gave rise to the Subscriber's COBRA coverage.

COBRA continuation coverage will be offered to qualified beneficiaries only after FCC is notified by the Employer that a qualifying event has occurred.

If the qualifying event is the reduction of hours, termination of employment, death of the Subscriber or the Subscriber's becoming eligible for Medicare, the Employer must notify FCC within 30 of the later of the date the qualifying event occurs or the date that coverage is lost on account of the qualifying event.

If the qualifying event is a divorce or legal separation or a child's loss of Eligible Dependent status, the Subscriber or the covered Dependent (or a representative) must inform the Employer within 60 days of the later of the date the qualifying event occurs or the date that coverage is lost on account of the qualifying event. In addition, in the event of the birth or adoption of a child after the qualifying event, the Subscriber must notify FCC of the birth or adoption of the child whom the Subscriber wishes to enroll under the Health Plan. The notice procedures are described below. If this notice is not timely and properly provided, the qualified beneficiary will not be permitted to elect COBRA continuation coverage.

Enrollment in COBRA Continuation Coverage

Once FCC gets timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries, each of whom will have an independent right to elect COBRA continuation coverage. Subscribers may elect on behalf of the non-Subscriber spouse and parents may elect on behalf of their Eligible Dependents. If an election is made by the Subscriber or the non-Subscriber spouse without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event. Once FCC receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered, when appropriate, to each of the qualified beneficiaries.

To elect COBRA continuation coverage, the election form must be completed and submitted to FCC by mail at the address specified above, by faxing it to the fax number listed above or by emailing it to enrollment@firstcarolinacare.com . If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the qualifying event (or, if later, the date coverage is lost on account of the qualifying event). The following are not acceptable as COBRA elections and will not preserve a qualified beneficiary's COBRA rights: oral communications, including in-person or telephonic statements about an individual's COBRA coverage.

When making the decision of whether to elect COBRA continuation coverage, a qualified beneficiary should keep in mind that he/she may have other options. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Additional information about many of these options can be found at www.healthcare.gov or by calling 1-800-318-2596.

A qualified beneficiary should compare other coverage options with COBRA continuation coverage and choose the coverage that best fits his/her needs. For example, if a qualified beneficiary moves to other coverage he/she may pay more out of pocket than he/she would under COBRA because the new coverage may impose a new deductible. When job-based health coverage is lost, it's important that a qualified beneficiary choose carefully between COBRA continuation coverage and other coverage options, because once the choice is made, it can be difficult or impossible to switch to another coverage option except in limited circumstances.

Additional information is provided below.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary extension of coverage. When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare, Subscriber's divorce or legal separation, or loss of Eligible Dependent status, COBRA continuation coverage lasts for up to 36 months.

In most cases, when the qualifying event is reduction in hours or termination of employment, the COBRA continuation coverage period is generally only up to 18 months. When the qualifying event is the end of employment or reduction in hours, and the Subscriber became entitled to Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare 8 months before the date of termination of employment, COBRA continuation coverage for his/her spouse and dependents can last up to 36 months after the date of Medicare entitlement, or 28 months after the date of qualifying event (36 minus 8).

If a qualified beneficiary becomes entitled to Medicare or first learns that he/she is entitled to Medicare after submitting a COBRA Election Form, the qualified beneficiary must notify FCC of the date of his/her

Medicare entitlement at the address specified herein. The notice procedures are described below.

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

The 18 month period can be extended in two other ways.

- Disability Extension
  If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled, the qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The SSA must determine that the qualifying disability started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period. To qualify for the extension, notice of the SSA's disability determination must be provided to the FCC COBRA Coordinator before the end of the first 18 months of continuation coverage and within 60 days after the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date the Subscriber terminated or reduced his/her hours of employment; and (3) the date on which the qualified beneficiary would lose coverage. The procedures for providing this notice are described below.

- Second Qualifying Event Extension
  If the Subscriber or Eligible Dependents has another qualifying event during the 18 month period (or 29 month period, if applicable), they may be eligible for up to 18 more months, for a maximum of 36 months of COBRA continuation coverage. This extension is available if, during the first 18 month (or 29 month) continuation coverage period, the Subscriber or former Subscriber dies, becomes entitled to Medicare, gets divorced or legally separated, or if the dependent loses Eligible Dependent status, but only if these events would have caused the Subscriber or Eligible Dependents to lose coverage if the first qualifying event would not have occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For cases of second qualifying events, the qualified beneficiary must notify FCC in writing within 60 days after the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would have lost coverage under the Health Plan due to the second qualifying event if it had occurred before the first qualifying event. The procedures for providing this notice are described below.

  Failure to provide timely and properly provide notice of a disability determination or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Termination of COBRA Coverage

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

- The qualified beneficiary receiving COBRA coverage first becomes covered under another group health plan after electing COBRA.

- The qualified beneficiary receiving COBRA coverage first becomes entitled to Medicare after electing COBRA continuation coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
- If coverage is extended beyond 18 months because of disability, the Social Security Administration makes a final determination that the qualified beneficiary is no longer disabled.
- The Employer terminates all group health plans for all active employees.

If, during the period of COBRA coverage, a qualified beneficiary becomes covered, after electing COBRA, under other group health plan coverage, the Subscriber or the qualified beneficiary (or a representative) must notify FCC in writing within 30 days of the date the other coverage becomes effective. If, during the period of COBRA coverage, a qualified beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, the Subscriber or the qualified beneficiary (or a representative of either) must notify FCC in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card). The procedures for providing this notice in both of these circumstances are described below.

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

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

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

Premium Payments

A qualified beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage (i.e., the cost paid by the employee and employer). The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

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

If the initial premium payment is not made by the end of the 45 day payment period, the qualified

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

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

Notice Procedures

As a condition of receiving COBRA coverage, the Subscriber or the Subscriber's Eligible Dependents who are covered under the Health Plan (or a representative) must notify FCC when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

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

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

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

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

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, a qualified beneficiary could be eligible for a new kind of tax credit that lowers monthly premiums and cost-sharing reductions (amounts that lower out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and a qualified beneficiary can see what the premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Through the Marketplace a qualified beneficiary can also learn if he/she qualifies for free or low-cost coverage from Medicaid or

the Children's Health Insurance Program (CHIP). The Marketplace for each state can be accessed at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit eligibility for coverage or for a tax credit through the Marketplace.

A qualified beneficiary has 60 days from the time he/she loses job-based coverage to enroll in the Marketplace. That is because losing job-based health coverage is a "special enrollment" event. After 60 days, this special enrollment period will end and the qualified beneficiary may not be able to enroll until annual enrollment. As a result, if a qualified beneficiary thinks that he/she may want Marketplace coverage, it is important to take action right away. In addition, a qualified beneficiary may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what individuals need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If a qualified beneficiary signs up for COBRA continuation coverage, he/she can switch to a Marketplace plan during a Marketplace open enrollment period. The qualified beneficiary can also end COBRA continuation coverage early and switch to a Marketplace plan if the qualified beneficiary has another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, a qualified beneficiary terminates COBRA continuation coverage early without another qualifying event, he/she will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once COBRA continuation coverage is exhausted and the coverage expires, a qualified beneficiary will be eligible to enroll in Marketplace coverage through a special enrollment period, even if he/she enrolls outside of the Marketplace open enrollment.

If a qualified beneficiary signs up for Marketplace coverage instead of COBRA continuation coverage, he/she cannot switch to COBRA continuation coverage under any circumstances.

A qualified beneficiary may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if enrollment is requested within 30 days of the loss of coverage. If a qualified beneficiary chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which he/she is eligible, the qualified beneficiary will have another opportunity to enroll in the other group health plan within 30 days of losing COBRA continuation coverage.

If you are a qualified beneficiary, when considering options for health coverage, you may want to think about:

- Premiums: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to

check to see if your current health care providers participate in a network as you consider options for health coverage.

- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Severance: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. Keep in mind that when these payments stop, you will be required to pay the full COBRA premium until you are allowed to enroll in the Marketplace, which may not be until the next annual enrollment.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For questions about the right to coverage, contact FCC.

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

Address Changes

In order to protect Member's rights under COBRA, it is important to notify the Employer and FCC of any address changes for Subscribers and Eligible Dependents. If a Subscriber changes his/her marital status, or a Subscriber or his/her Eligible Dependents have changed addresses, it is the Subscriber's responsibility to notify the Employer and FCC. Members also should keep copies of any notices sent to the Employer or to FCC.

FCC Contact Information

The FCC COBRA Coordinator may be reached at 910-715-8100 or at:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

Continuation Coverage under State Law

If a Subscriber's Employer is not subject to COBRA (if the Employer has 19 or less full-time employees or is a church or governmental plan), a Subscriber may be eligible for 18 months of continuation coverage under North Carolina law.

The Subscriber may choose coverage for himself or herself and his or her family members in the event

the coverage is lost due to termination of the employment or reduction in the hours of employment.

If entitled to state continuation coverage, the Subscriber must:

- Notify the Employer of any of the qualifying events listed above;
- Elect state continuation coverage within 60 days after eligibility ends by notifying FCC and paying the required initial premium; and
- Pay monthly premiums when due.
- FCC may charge an additional 2% administrative fee over the total premium rate for administration costs.

State continuation coverage is subject to these conditions:

- A Subscriber must be covered in the group plan for the entire three months just before the date coverage ends;
- A Subscriber will not be eligible if:
- Coverage ended because of a failure to pay the employee portion of the cost;
- The Subscriber is eligible for similar benefits under another health plan within 31 days after the end date of coverage; or
- The Master Employer Agreement ends and the Employer replaces it with similar coverage within 31 days.

State continuation coverage will end:

- The date 18 months after the date the Subscriber lost eligibility;
- The date that ends the period for which premium was last paid;
- The date a Member becomes eligible for coverage under another group plan; or
- The date the Master Employer Agreement ends (If the Employer replaces the FCC with another group plan, state continuation coverage may be continued under that group plan for the remaining period).

Individual Conversion Coverage

North Carolina law provides for conversion coverage under certain conditions. Conversion coverage is a form of individual coverage that may be issued without evidence of insurability to Members who lose group coverage due to termination of the group plan or exhaustion of continuation coverage.

Conversion coverage is not available if the Member:

- Was terminated for cause from a health maintenance organization;
- Terminated employment and either was not entitled to elect or failed to elect continuation coverage under NCGS § 58-53-5;
- Failed to make timely premium payments or contributions for coverage;
- Failed to exhaust available continuation coverage;
- Is eligible for Medicare or any other public insurance program;
- Is eligible for enrollment in a group health plan offering similar benefits.

If FCC gets notice that an Employer has terminated the group plan without intentions of continuing to offer group health insurance, individual conversion coverage will be offered to Members who had elected continuation coverage under NCGS § 58-53-5 if the date of the group termination precedes the date of the Member's actual continuation under NCGS § 58-53-5. A Member must request conversion coverage and pay the initial premium within 31 days of the termination of coverage.

Individuals losing coverage may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, the individual may qualify for a 30-day special enrollment period for another group health plan for which he/she is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additional information is provided above under "Health Insurance Marketplace."

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

FCC is committed to its Members and their rights. Members of FCC have the right to:

- Seek privacy and respect.
- Choose a Primary Care Provider (PCP) from a list of Participating PCPs.
- Approve or refuse the release of personal information except when it is allowed or required by law.
- Help the Provider and FCC make decisions about health care options.
- Obtain health records in a lawful manner.
- Receive printed materials about benefits, services and Participating Providers. If this information is not received or if there are any questions, Members may contact Member Services.
- Obtain information on Participating Providers; ask about their qualifications.
- Contact FCC to make complaints or suggestions about Providers, services, benefits or any other aspect of FCC.
- Make advance directives.
- Be told by Providers what they know about a Member's health condition. This includes information on:
  - Diagnosis,
  - Prognosis,
  - Treatment options, and
  - Possible risks and complications.

Member Responsibilities

The following is a list of ways Members can share in the responsibility for their health:

- Comply with the requirements for coverage under this Certificate.
- Establish a Provider/patient relationship with a PCP.
- Work with a PCP to plan and set up health care services.
- Carry the FCC ID card at all times.
- Present an FCC ID card when getting health care services and protect the ID card from unauthorized use.
- Make appointments in advance.
- Keep appointments.
- Call in advance if an appointment must be missed.
- Use Wellness and Preventive Services.
- Inform Providers about health status.
- Tell FCC and the Employer of other health coverage, address changes or qualifying events.
- At the time of service, pay all Copayments, Coinsurance and Deductibles charged by the Provider.
- Tell the Employer at least five (5) business days before the end of the month (or as directed by the Employer) of any changes to coverage.
- Ask questions about benefits before getting services.
- Use health care resources responsibly.
- Take advantage of the Nurse Help Line.
- Make sure all necessary Certifications have been obtained.

Advance Directives

An advance directive is the directions a person may write to tell Providers how the person wants to be treated if the person becomes very ill and not able to talk or think clearly. These directions contain the person's wishes about accepting or refusing certain care or treatment. Advance directives may contain instructions about the following:

- What medical treatments a person wishes to receive or refuse.
- Who will make health decisions for a person when he/she is very sick and unable to do it himself/herself.

- What treatments a person will accept and refuse and the person who should make decisions for them.

FCC encourages Members to think about treatment options in the case of a serious illness or injury, and to discuss them with a PCP. Advance directives are not required. If a Member does have an advance directive, copies should be given to regular Provider(s) and to family members.

Members will not be treated differently by FCC or Provider based on whether or not there is an advance directive. For more information on advance directives, Members should contact their Provider or lawyer.

GENERAL PROVISIONS

Notices

To FCC: Notices may be sent by U.S. Mail postage prepaid, addressed as follows:
FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

To Members: To the latest address provided on an enrollment form or on a change of address form received by FCC.

Independent Contractor Relationship

The relationship between FCC and Participating Providers is a contractual relationship. Providers are not agents or employees of FCC just because they are listed as Participating Providers. FCC is not an agent or employee of any Providers. Subject to North Carolina law governing the liability of managed care organizations, FCC is not liable for the independent actions of Providers and Providers are not liable for the independent actions of FCC.

Warranties

FCC makes no explicit or implied warranties concerning the credentials of any Participating Provider. It does not guarantee continued participation in the FCC network by any Participating Provider. A Provider may decide not to participate at any time without advance notice to Members or their Employer.

Waiver Of Certificate Provision

On occasion, FCC may choose not to enforce all of the terms and conditions of the Certificate of Coverage. This does not mean that FCC gives up any rights to enforce any provision of the Certificate of Coverage in the future.

Unenforceability Or Invalidity Of Any Provision

If any provision of this Certificate or in the Master Employer Agreement is held to be against the law or invalid under law, it will be removed from the Certificate or the Master Employer Agreement. All other provisions will remain in effect.

Amendment And Termination

Under the Master Employer Agreement, the Employer has the right to terminate coverage under this Certificate upon 30 days prior notice to FCC, subject to the requirements described in the "Special North Carolina Notice" section at the front of the Certificate. Members may lose coverage under this Certificate, or coverage and premiums may change if the Employer or FCC amend the Master Employer Agreement or this Certificate. In no event do Members have vested rights in the Master Employer Agreement or this Certificate.

Discretionary Authority
FCC reserves the discretionary authority to determine eligibility for benefits under and to interpret the terms and provisions of this Certificate of Coverage, subject to the objective terms of the Certificate of Coverage and applicable regulatory requirements governing the administration of group health plans. Such determinations and interpretations will not be overturned by a court of law unless found to be arbitrary and capricious.

Value-Added Services
From time to time FCC or its marketing partners may make available to certain Members certain non-insurance benefits or services designed to improve the health and enhance the quality of life of Member. Those benefits or services may include:

- Nurse Help Line, or
- Periodic newsletter.

These programs may be offered directly by FCC or through third parties and vendors and are subject to change or termination without prior notice. FCC does not endorse and is not responsible for the products, services or information provided by third party service providers. Arrangements and discounts were negotiated between each vendor and FCC or its marketing partners for the benefit of Members. These programs are not considered insured benefits under this Certificate, but are value-added benefits which may be made available to Members.

While FCC or third party vendors have arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the Member for the provision of such goods and/or services. FCC is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, FCC is not liable to the Member for the negligent provision of such goods and/or services by third party service providers.

Attachment A
Services Requiring Pre-certification

1. Inpatient
    - Medical
    - Surgical
    - Maternity and newborn hospitalizations that exceed the standard length of stay
    - Rehabilitation
    - Hospice inpatient
    - Skilled Nursing Facility
    - Long Term Acute Care (LTAC)
2. Behavioral Health- Inpatient and Intensive Outpatient (IOP)
3. Chemical Dependency
    - Inpatient
    - Intensive Outpatient (IOP)
    - Methadone Maintenance
4. Transplants
5. Imaging
    - MRI/MRA
    - PET Scan
    - SPECT Scan
    - CT/CTA
    - Bone Scan
6. Genetic Testing
7. Some Outpatient Surgical Procedures
8. Durable Medical Equipment purchases over $750
9. Durable Medical Equipment rentals
10. Orthotic and Prosthetic purchases over $750
11. Any services that might be Cosmetic Procedures but are Covered Services under certain medical circumstances, such as breast reduction surgery
12. Colonoscopy
13. EGD
14. Audiogram
15. Sleep Study
16. Medical Nutritional Counseling
17. Hyperbaric oxygen therapy
18. Physical therapy
19. Speech therapy
20. Occupational therapy
21. Home Health Services
22. Hospice - Outpatient
23. Home Infusion
24. Bariatric Surgery
25. Anesthesia and Facility services related to Dental Services
26. Ambulance
    - Non-emergent transportation
    - Air transport
27. Injectable Drugs received in an outpatient setting

This list may be amended by FirstCarolinaCare Insurance Company from time to time. The Member is encouraged to call Medical Management at (800) 574-8556 prior to receiving services other than Emergency Services.

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

For more information, you may contact:

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605 -0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE
Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE
However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects

insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

AMENDMENT TO CERTIFICATE OF COVERAGE

2016 Certificate of Coverage
Point of Service Plan

Exclusions and Limitations

The Exclusions and Limitations section in the COC is replaced with the following revised language:

EXCLUSIONS AND LIMITATIONS

The following services, items, and supplies are not Covered by FCC:

1. Treatment, services or supplies for an injury or sickness as a result of war or an act of war, declared, or undeclared. This includes the treatment of disabilities, diseases or injuries resulting from military service.

2. Services, treatment or supplies if no charge would have been made if the Member did not have this coverage. This includes services, treatment or supplies received from a person who normally lives in the Member's household or is a member of his/her immediate family (closely related, such as parent, grandparent, sibling, child).

3. Health services for injury received while a Member is engaged in an act that has been prosecuted or may be prosecuted as a misdemeanor or felony by an appropriate law enforcement agency.

4. Custodial Care.

5. Services, treatment or supplies in a facility, or part of a facility, that is mainly a place for (a) rest, residence or assisted living; (b) convalescence; (c) Custodial Care; (d) the aged; or (e) training or schooling. This exclusion includes, but is not limited to, charges for residential treatment centers (by whatever name). This exclusion does not apply to services that meet the terms and conditions described under "General Coverage Rules," which will be Covered Services under the same terms and conditions as would apply if the Member were residing in a private living space.

6. Experimental/Investigational treatment, services, drugs or supplies, including any related diagnostic services, exams or supplies and regardless of the applicable sickness or injury. This exclusion does not apply to services for which benefits are available under this Certificate for a Covered Clinical Trial or an Approved Clinical Trial.

7. Purchase or fitting of glasses or contact lenses, except for one pair immediately following cataract surgery, unless the Employer purchased a Vision Rider to be included with this Certificate.

8. Routine eye exams or other routine eye services, vision screenings or tests unless the Employer purchased a Vision Rider to be included with this Certificate. This exclusion

does not apply to one routine annual eye exam for Members with a medical diagnosis of diabetes.

9. Radial keratotomy, myoptic keratomileusis, and any surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia or stigmatic error.

10. Dental Services, except those specifically listed as Covered in "Covered Services", including but not limited to services related to dentures, orthodontia, crowns, bridges, periodontal disease, root canals, dental root form implants and oral surgery.

11. Services, treatment or supplies for obesity, weight reduction or weight control, except surgery that meets the requirements for "Bariatric Weight Loss Surgery" under "Covered Services."

12. Services, treatment or supplies for weak, strained or flat feet, or instability or imbalance of the feet, including orthopedic shoes or other supportive devices.

13. Cutting, removal or treatment of corns, calluses or toe nails. This exclusion does not apply to routine foot care for Members with a medical diagnosis of diabetes.

14. Services, treatment or supplies for complications related to or arising from treatment or an operation to improve appearance if the original treatment or operation either was not a Covered Service or would not have been a Covered Service if the individual had been a Member.

15. Cosmetic services. This includes any surgery done primarily to improve the appearance of any part of the body and not to improve physical function. Some examples are:
    - surgery for sagging or extra skin;
    - any enlargement or reduction procedures;
    - rhinoplasty and associated surgery; and
    - any procedures utilizing an implant that does not change physical function or is not incident to a surgical procedure.

    This exclusion does not apply to: reconstructive surgery following an injury or to correct a congenital defect for newborn, adoptive and foster children or reconstructive surgery on a non-diseased breast as outlined under “Covered Services” above and in NCGS 58-51-62.

16. Services, treatment or supplies for Sexual Dysfunction unless related to organic disease.

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

18. Maternity benefits for Eligible Dependents other than spouses. Complications of Pregnancy are Covered for all Members.

19. Private duty nursing.

20. Services, treatment or supplies for infertility such as artificial insemination or an implant procedure to induce pregnancy, in vitro fertilization, fertility drugs, sonograms or other fertility procedures.

21. Reversal of surgical sterilization.

22. Genetic testing. This exclusion does not apply to genetic testing listed as a Covered Service under either the “Imaging and Laboratory Services,” “Women’s Health” or the “Maternity Care” section.

23. Biofeedback, environmental therapy, acupuncture, acupressure, massage therapy, herbal, nutritional and hypnotherapy services.

24. The replacement of an initial prosthesis due to loss, theft, or destruction, not including the trainer temporary prosthesis.

25. Services, treatment or supplies for mental retardation, behavioral developmental delay disorders or learning disabilities except limited diagnostics and education expressly listed under "Covered Services."

26. Services or supplies for the treatment of an occupational injury or sickness that are paid or payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

27. Personal convenience items that are not directly related to Covered Services. Examples of excluded items include telephone, television or the rental of such items whether in an inpatient, outpatient or home setting; air conditioners, humidifiers, dehumidifiers and air purifiers; exercise equipment, arch support or orthotics used for participation in sports.

28. Abortion, unless the life of the mother would be endangered by carrying the fetus to term.

29. Any medical, psychological or psychiatric services, treatment or supplies that are the result of a court order or required by a third party, unless Medically Necessary or required by a Qualified Medical Child Support Order.

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

31. Premarital laboratory work required by any state or local law.

32. Charges for medical reports or for the completion of forms unless requested by FCC.

33. Examinations for obtaining or maintaining employment, insurance, professional, or other licenses, school exams and sports physicals.

34. Appearances at hearings and court proceedings by a Provider.

35. Immunizations for international travel.

36. Travel and transportation expenses. Travel and transportation expenses related to transplants may be Covered when Certified by FCC.

37. Sclerotherapy (injection of sclerosing solutions) for the treatment of varicose veins for cosmetic reasons.

38. Charges for missed or canceled appointments.

39. Any service, supply or treatment for which a chelating agent is used except for the treatment of heavy metal poisoning.

40. Any service, supply or treatment in excess of any applicable limit or maximum as stated in this Certificate or in the Schedule of Medical Benefits.

41. Covered Services for which payment has been made under Medicare or any other federal, state or local government program (excluding Medicaid).

42. Medical or surgical complications resulting from a non-Covered service, except for Emergency Medical Services.

43. Extra charges above the usual fee for obtaining, storing or administering donated blood. This includes a Member arranging for blood donations to be used by the Member at a future time.

44. Hearing exams, tests, hearing aids and other routine hearing care services, treatments and supplies. This exclusion does not apply to Covered hearing exams for newborns and children under the age of 17 and coverage for hearing aids for Members under 22 years of age as described under “Hearing Aids” in the Covered Services section.

45. Purchase or fitting of corrective shoes, devices, or appliances except orthotics as specifically stated under Covered Services.

46. Services, treatment or supplies received more than 180 days prior to submission of a Claim to FCC unless it was not reasonably possible for the Claim to be filed within the 180 day period. In such case, Claim must be filed as soon as reasonably possible but in no case later than 1 year from the time submittal of the Claim is otherwise required, except in the absence of legal capacity of the Member. The 1 year extension, if applicable, does not require FCC to make payments to Participating Providers whose contracts allow a shorter period in which to file claims. However, the 1 year extension stated in this paragraph will be applied to any claims filed by Members for Covered Services rendered by Non-Participating Providers.

47. Services, treatment or supplies for which the Member has no financial obligation or where he/she is not required to pay Coinsurances, Deductibles or Copayments.

48. The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.

49. Services, treatment or supplies received from the Member's close relative or a person living in the Member's household.

50. Donor eggs and sperm; services received by an organ donor if not a Member.

51. Surrogate mothers.

52. Treatment for infertility or reduced fertility that results from a prior procedure resulting in sterilization or a normal physiological change such as menopause.

53. Counseling with relatives about a patient.

54. Inpatient confinements that are primarily intended as a change of environment.

55. Group therapy for Pulmonary Rehabilitation.

56. Wigs, hair replacement, hair prosthesis, cranial prosthesis; hair implants or hair plugs; except one wig/ scalp hair prosthesis per lifetime for hair loss due to chemotherapy for cancer with the limits as specifically noted under Covered Services.

57. Adaptive Behavioral Treatment [except Medically Necessary Adaptive Behavioral Treatment for Members diagnosed with Autism Spectrum Disorder.]

Discrimination is Against the Law

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

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

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

FCC Civil Rights Coordinator
FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Telephone: 910-715-8114
Fax number: 910-715-8101
Email: fccFMD@firstcarolinacare.com

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

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

MULTI-LANGUAGE
INTERPRETER SERVICES

English

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-800-811-3298 (TTY 711).

Español (Spanish)

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

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-201-4957（TTY 711）。

Tiếng Việt (Vietnamese)

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

한국어 (Korean)

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

Français (French)

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

العربيـــــة (Arabic)

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

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

Hu rau 1-800-811-3298 (TTY 711).

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

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong

sa wika nang walang bayad. Tumawag sa 1-800-811-3298 (TTY 711).

ગુજરાતી (Gujarati)

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

ខ្មែរ (Cambodian)

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

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche

Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-811-3298 (TTY 711).

हिंदी (Hindi)

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

ພາສາລາວ (Lao)

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

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-201-4957（TTY:711）まで、お電話にてご連絡ください。