Carolinas HealthCare System

Uncompromising Excellence. Commitment to Care.

SUMMARY PLAN DESCRIPTION

for

PLAN PARTICIPANTS

of

CAROLINAS HEALTHCARE SYSTEM

LiveWELL HEALTH PLAN

Amended and Restated January 1, 2017

IMPORTANT NOTICE

The Schedule of Benefits included in this Summary Plan Description (SPD) is an outline of benefits of the Employee Benefits Plan provided by your Employer. The basis of payment of the benefits described herein will be determined by the provider of services and claims rules of the Plan. All benefits described in the SPD are subject to the exclusions and limitations described more fully herein.

This Summary Plan Description contains a summary in English of your Plan rights and benefits under your Health Plan. If English is not your first language and you have difficulty understanding any part of the Summary Plan Description, contact MedCost Benefit Services Customer Service at (800) 795-1023. Office hours are from 8:30 a.m. to 5:00 p.m. (Eastern Time) Monday through Friday.

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INTRODUCTION

Note to Plan Participants

- Capitalized terms have specific meanings when used in this document. The meanings of these capitalized terms are in the *Defined Terms* section of this document.
- This Summary Plan Description describes the circumstances when this Plan pays for health care. All decisions regarding health care are up to the Plan Participant and his or her Physician. There may be circumstances when a Plan Participant and his or her Physician determine that health care, which is not covered by this Plan, is appropriate. The Plan Sponsor does not provide nor ensure quality of care.
- Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, benefit coverage, deductibles, maximums, copays, exclusions, limitations, definitions and eligibility.
- The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
- If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Purpose

- This document is a Summary Plan Description of "Carolinas HealthCare System LiveWELL Health Plan" (the Plan).
- The Plan described is designed to protect Plan Participants against certain health expenses.
- The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered health expenses incurred by Plan Participants.
- The Plan is not to be construed as a contract for or a guarantee of employment. Nothing in this Plan shall be deemed to:
  - Affect the right of the Employer to discipline or discharge any Employee at any time.
  - Affect the right of any Employee to terminate his or her employment at any time.
  - Give the Employer the right to require any Employee to remain in its employ.
  - Give any Employee the right to be retained in the employ of the Employer.

Exclusive Benefit

- This Plan is established and shall be maintained for the exclusive benefit of eligible Plan Participants.
- The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
- Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change this Plan.
- No action at law or in equity shall be brought to recover any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after time when written proof of loss is required to be furnished to the Third Party Administrator.
- Failure to follow the eligibility or enrollment requirements, including timely application for coverage of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other health management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.
- Should any part of this Summary Plan Description for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Summary Plan Description has been executed with the invalid portion thereof eliminated.

Document Sections

This summary plan document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

- *General Plan Information*
- *Schedule of Benefits* - Provides an outline of the Plan's payment or reimbursement as well as limits on certain services
- *General Provisions* **-** Explains Employee and Dependent eligibility for coverage under the Plan, funding of the Plan, Special Enrollment Rights and when the coverage takes effect and terminates
- *Coverage of Medical Expenses* - Provides a description of covered medical expenses and explains when the benefit applies and the types of charges covered
- *Prescription Drug Benefits*
- *Medical Benefit Exclusions* - Provides a list of charges that are *not* covered
- *Health Management Services* - Explains the Plan's programs used to help Plan Participants curb unnecessary and excessive charges, Plan Participant's responsibilities for health management, and possible penalties that may be assessed for failure to follow Health Management requirements
- *Claims Procedures and Appeals* - Describes how to submit a claim, how the Plan processes claims and explains the rules of the claim appeal process
- *Coordination of Benefits* - Shows the Plan order of payment when a Plan Participant is covered under more than one plan
- *Reimbursement and/or Subrogation* - Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person or entity because of injuries sustained
- *Continuation Coverage Rights Under COBRA* - Explains the continuation options that are available when a Plan Participant's coverage under the Plan ceases
- *Defined Terms* - Defines those Plan terms that have a specific meaning
- *HIPAA Privacy Standards* - Explains how an employer may use and disclose a Plan Participant's Protected Health Information (PHI) in addition to the restrictions placed on such use and disclosure.

FRAUD

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

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

A Covered Person must:

- file accurate claims; if someone else - such as the Spouse or another Family member - files claims on the Covered Person's behalf, the Covered Person should review the Claim Form before signing it;
- review the Explanation of Benefits (EOB) Form and be certain that benefits have been paid correctly based on his/her knowledge of the expenses incurred and the services rendered;
- never allow another person who is not his/her Dependent to seek medical treatment under his/her identity; and if the Covered Person's Plan identification card is lost, report the loss to the Plan immediately;
- provide complete and accurate information on Claim Forms and any other forms; and answer all questions to the best of his/her knowledge; and
- notify the Plan when an event occurs that affects a Covered Person's eligibility.

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

- bills for services or treatment that have never been received; and/or
- asks a Covered Person to sign a blank Claim Form; and/or
- asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB Form, or who know of or suspect any illegal activity, should call toll-free (800) 795-1023. All calls are strictly confidential.

RESCISSION OF COVERAGE

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Plan Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Plan Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Plan Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Plan Participants being canceled, and such cancellation may be retroactive.

A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Patient Protection and Affordable Care Act (PPACA) and applicable regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION: The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME: Carolinas HealthCare System LiveWELL Health Plan

EMPLOYER GROUP NUMBER: 300

TAX ID NUMBER: 56-0529945

PLAN EFFECTIVE DATE: January 1, 2000
Revised and Restated January 1, 2008; Amended and Updated January 1, 2009; Amended April 1, 2009; Amended April 29, 2009; Amended October 1, 2009; Amended January 1, 2010; Amended February 1, 2010; Amended May 1, 2010; Amended June 1, 2010; Amended September 1, 2010; Amended October 1, 2010; Amended and Restated January 1, 2011; Amended May 16, 2011; Amended July 1, 2011; Amended and Restated January 1, 2012; Amended August 1, 2012; Amended November 1, 2012; Amended and Restated January 1, 2013; Amended January 1, 2013; Amended July 1, 2013; Amended August 1, 2013; Amended August 15, 2013; Amended September 1, 2013; Amended and Restated January 1, 2014; Amended May 1, 2014; Amended September 1, 2014; Amended October 10, 2014; Amended December 1, 2014; Amended and Restated January 1, 2015; Amended January 1, 2015; Amended and Restated January 1, 2016; Amended October 1, 2016; Amended and Restated January 1, 2017.

PLAN YEAR: January 1st through December 31st

PLAN YEAR ENDS: December 31

BENEFIT YEAR: January 1st through December 31st

EMPLOYER INFORMATION:
Carolinas HealthCare System
PO Box 32861
Charlotte, North Carolina 28640
(704) 631-0263

AGENT FOR SERVICE OF LEGAL PROCESS
Carolinas HealthCare System
PO Box 32861
Charlotte, North Carolina 28640

THIRD PARTY ADMINISTRATOR
MedCost Benefit Services, LLC
165 Kimel Park Drive
Winston-Salem, North Carolina 27103
(336) 774-4400

CLAIMS ADMINISTRATOR
MedCost Benefit Services*
PO Box 25987
Winston-Salem, North Carolina 27114-5987
(800) 795-1023

**In compliance with California law, MedCost Benefit Services operates in the state of California as "MedCost Benefit Services d/b/a MBS Third Party Administrators."*

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

Health Claims
Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

NOTICE OF PRECERTIFICATION REQUIREMENTS

IMPORTANT NOTICE
Certain medical services require Precertification.

Precertification* is the process of collecting certain information before elective inpatient admissions and/or selected ambulatory procedures and services take place. Not all medical services are covered under the Plan. When Precertification is required, failure to follow the Precertification process as described herein in advance of a procedure or service may result in significant penalties as defined in this SPD, including non-coverage. Requests for Precertification and notification must be received before receipt of a service or procedure. Failure to contact MedCost for Precertification will relieve MedCost or the Employer from any financial liability for the applicable service(s) or product(s), unless otherwise stated in this SPD.

*Precertification means the utilization review process to determine whether the requested service, procedure, Prescription Drug, or medical device meets the clinical criteria for coverage. See the Health Management Services section.

Schedule of Benefits 2017	
For access to information 24/7, go to ***www.medcost.com*** and go to Member Login to visit the personalized website; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or ***mbscs@medcost.com***; please include Member ID in body of email. ***See remainder of the Summary Plan Description for further details.***	
Waiting Period (*Full-Time / Part-Time as defined) New Hires*	30 days of continuous employment with the Employer as defined in Eligibility section of Plan. Effective: Upon completing the Waiting Period, coverage will begin the first day of the following month.
Waiting Period *(Other) New Hires*	Students enrolled as medical residents, in the pastoral residency program, or in the School of Anesthesiology as well as Employees transferring from one of the leased or managed facilities of CHS do not have to complete the Waiting Period. *See also acquired companies in Eligibility section.* Effective: Date of Hire
Waiting Period *(Rehires)*	A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or her termination date will not be required to satisfy the Employer's Waiting Period.
Spousal Definition*	"Spouse" shall mean a person to whom you are married. The Employer may require documentation proving a marital relationship. *Note:* The Plan does not offer coverage to a domestic partner.
***Smoker / Tobacco User Premium Surcharge**	The Carolinas HealthCare System LiveWELL Health Plan includes a premium surcharge to encourage healthy decisions regarding tobacco use. For questions, contact the Benefits Department at (704) 631-0263.
Dependent Children	Coverage will end the end of the month during which the Dependent child's 26th birthday occurs.
Open Enrollment	Benefit choices made during Open Enrollment are effective on January 1st.
Leave of Absence	FMLA. *See remainder of Summary Plan Description.* Other than FMLA. *(Not specified in remainder of SPD. See CHS Policy and Procedural Manual / contact Employee Benefits Department)*
Pre-Existing Conditions	This Plan does not impose a pre-existing conditions exclusion period.
Network Management	
Network	MedCost (excluding all Novant Health facilities)
Out-of-Area / Travel	AHA travel option 1
All Novant owned and affiliated health facilities are Non-Network including for preventive services, except in the case of a medical emergency or in documented situations where the service cannot be performed by another in-network provider. *See Defined Terms, Emergency Medical Condition.*	
For Plan Participants who reside in North Carolina and South Carolina:	If the Plan Participant's residence is not within 50 miles of a CHS Physician, Plan benefits can be paid at the 'CHS Provider' level of benefits as long as the treatment is being rendered at a MedCost Network provider. This exception does not apply to non-CHS facilities. Novant / Presbyterian will continue to be considered as Non-Network.
CHS Network*	*See the CHS website at ***www.carolinashealthcare.org*** to find a CHS facility or physician. *Note:* Charges from the following facilities *may* be paid at the 'CHS Provider' level of benefits:

- Albemarle Women's Clinic, PA
- Aswad Surgical Group, PC
- Cabarrus Ear Nose Throat & Facial Surgery PA
- Cabarrus Eye Center, PA
- Cabarrus Gastroenterology Associates, PLLC
- Cabarrus Pathology Associates PA
- Carolina Asthma & Allergy Center, PA
- Carolina Digestive Health Associates, PA
- Carolina Neurosurgery & Spine
- Carolina Pulmonary and Critical Care, P.A.
- Carolina Urology Partners, PLLC
- Carolinas Pathology
- Charlotte Eye Ear Nose & Throat Associates, P.A.
- Charlotte Radiology
- Fresenius/BMA/RAI
- Gateway Surgical Center
- Horizon Eye Care PA
- Lakeshore Pediatric Center, PA
- Leonard D Saltzman MD PA
- Lincoln Internal Medicine PA
- Metrolina Eye Associates, PLLC
- New Hanover Regional
- North State Medical Group, PA
- NorthEast Ear, Nose & Throat Center, P.A.
- OrthoCarolinas
- Paragon Surgical Specialists
- Piedmont Surgical Clinic, PA
- Rufus S. Lefler, III, MD

• Children's Urology of the Carolinas, PLLC • Cleveland Gastroenterology Associates in Shelby, NC • Concord Children's Clinic • Cone Health Facilities and Physicians • CornerStone Ear, Nose & Throat, PA • David A. Nachamie, M.D. • Dermatology Group of the Carolinas	• Shelby Medical Associates • Shelby Radiology • Shelby Surgical Associates, PA • Southeast Radiation Oncology Group, PA • The Stone Institute • Surgical Specialists of Charlotte, P.A. • Urology Specialists of the Carolinas, PLLC

Health Management	
Precertification	• Hospital admissions • transplant services • Hospital observation unit stays of more than 48 hours • dialysis services* • Mental Health / Substance Use Disorders – *See Appendix A / precertification by CBHA required.*
	*Failure to precertify dialysis will result in associated charges from the first treatment date being denied.
Case Management	Case Management is a program that provides special intervention during care or treatment for serious illnesses and accidents. *See also separate Transplant benefit*.
	Call (800) 722-2157, extension 6509.
Personal Care Management	Personal Care Management is a program to assist with early identification of individuals who may be at risk for developing serious and costly diseases.
	Call (800) 722-2157, extension 6509.
SmartStarts Prenatal Program	SmartStarts is a voluntary Employee wellness program, focused on educating expectant mothers and mentoring them through each trimester of pregnancy.
	Incentive: Health Savings Account (HSA) contribution. *See remainder of Summary Plan Description for details*. Call (800) 722-2157, extension 4211.
Diabetic Care Management	The Plan will provide coverage for Medically Necessary diabetes outpatient self-management training and educational services. Refer to Nutritional Counseling for further details.
	Participation is tied to the CHS LiveWELL Incentive program. The Diabetic Care nurse can provide details, or teammate can call LiveWELL at (704) 355-8136.
Employee Assistance Program	Available through Carolinas HealthCare System, this program is designed to help you and members of your family with all types of issues – marital conflict, financial problems, job stress, emotional problems, alcohol and drug problems, legal issues and difficulties with children. Call (800) 384-1097.
Wellness Program	LiveWELL is the CHS employee wellness program that provides a wide range of services including nutrition and weight loss resources, fitness classes, smoking cessation and more. Visit ***http://livewell.carolinashealthcare.org*** or call (704) 355-8136.
On-Site Care	CHS On-Site Care❖ is available to all Employees of Carolinas HealthCare System, including those enrolled in the LiveWELL Health Plan as well as those who are not enrolled in the Plan. CHS On-Site Care is for CHS employees only. Charges before the deductible are $40, $70, or $120, depending on the level of care provided. To make an appointment, call (704) 512-3971. Charges apply toward the Deductible; when the Deductible is met, the $10 Copay will apply toward the Out-of-Pocket maximum.
CHS Virtual Visit	The CHS Virtual Visit benefit is available to all Employees of Carolinas HealthCare System who are enrolled in the LiveWELL Health Plan as well as those who are not enrolled in the Plan, as well as dependents enrolled in the Plan, with the exception of ages 13 through 17. The Virtual Visit benefit provides a Plan Participant with the opportunity to communicate his or her health concerns and questions by speaking directly with a medical provider on-line at the mutual convenience of the Plan Participant and the provider. Plan Participants who have not met the Benefit Year Deductible will be billed $35 for each CHS Virtual Visit. Plan Participants who have met the Benefit Year Deductible will be billed $5 for each CHS Virtual Visit. No Copay will be billed once the Out-of-Pocket Maximum has been met. For more information, call CHS Virtual Visit at (855) 438-0010.

Benefit Maximums / Deductibles / Out-of-Pocket			
This Plan does not apply a Lifetime or Annual Benefit Maximum to each Plan Participant for the total claim expenses incurred and paid while covered under this Plan.			
Benefit Year	January 1st through December 31st		
Benefit Year Deductible			
	CHS Network	***Other In-Network***	***Non-Network***
Single Unit	$1,850	$2,600	$4,000
Family Unit	$3,700	$5,200	$8,000
Non-Embedded Deductible	The Family Plan requires the entire Family Deductible to be satisfied before benefits are paid for any Family members.		
	Network and Non-Network accumulate towards each other.		
Out-of-Pocket Maximum			
	CHS Network	***Other In-Network***	***Non-Network***
Individual	$5,600	$6,450	$11,000
Family	$11,200	$12,900	$22,000
	Network and Non-Network accumulate towards each other.		
	The Out-of-Pocket Maximum includes Copays, Coinsurance, and Deductibles, including On-Site Care and CHS Virtual Visit cost sharing, and excludes non-covered services, premiums, and any applicable penalties.		
Inpatient Hospital Services			
	CHS Network	***Other In-Network***	***Non-Network***
Room and Board	70% after deductible	60% after deductible	50% after deductible
Precertification required	Includes the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center; after 48 observation hours, a confinement will be considered an inpatient confinement and will *require* precertification. Payment for Critical Care Room and Board will be based on the Hospital's ICU charge. **Note for Non-Network:** If you occupy a private Hospital room, you will pay the difference between the Hospital's charges for a private room and the charge for a semiprivate room. If the Hospital does not have semiprivate rooms or a semiprivate room is unavailable, or your medical condition requires a private room (as determined by the Claims Administrator), the Plan will consider the private room rate.		
Physician Inpatient Services	75% after deductible	70% after deductible	50% after deductible
	The Plan covers professional services of a Physician for Inpatient surgical or medical services.		
Other Inpatient Services	70% after deductible	60% after deductible	50% after deductible
Emergency and Urgent Care Services			
	CHS Network	***Other In-Network***	***Non-Network***
Emergency Room Treatment, *including related services*	75% after CHS deductible		
Urgent Care - *Facility*	75% after CHS deductible		50% after deductible
Urgent Care Clinic - *Office*	75% after CHS deductible		50% after deductible
Outpatient Hospital Services			
	CHS Network	***Other In-Network***	***Non-Network***
Pre-Admission Testing	70% after deductible	60% after deductible	50% after deductible
	The Plan will pay for diagnostic tests and X-rays when performed on an outpatient basis before a Hospital admission, provided the procedures are provided within 7 days of the admission, are related to the condition that causes the admission and are performed in lieu of tests while Hospital confined. Payment will be made even if tests show that the condition requires medical treatment prior to Hospital admission or the Hospital admission is not required.		
Outpatient / Ambulatory Surgery			
Facility	70% after deductible	60% after deductible	50% after deductible
Surgeon	75% after deductible	70% after deductible	50% after deductible
	When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant		

	surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.		
Outpatient Laboratory and X-Ray Services	70% after deductible	60% after deductible	50% after deductible
Outpatient Diagnostic Scans - *MRI, CT, PET*	75% after deductible	75% after CHS deductible	50% after deductible
Other Outpatient Services	70% after deductible	60% after deductible	50% after deductible
Physician Services			
	CHS Network	***Other In-Network***	***Non-Network***
Note, for On-Site Care claims: Charges apply toward Deductible then, when the Deductible is met, the $10 copay will apply toward Out-of-Pocket maximum.			
Office Visit for Injury / Illness - Includes coverage of Smoking Cessation services as any office visit. See also Routine Wellness if billed under Routine. See also CHS Virtual Visit under Health Management section.			
Primary Care	75% after deductible	70% after deductible	50% after deductible
	General practitioner, family practitioner, internist and pediatrician.		
Office Surgery	75% after deductible	70% after deductible	50% after deductible
Office Laboratory & X-rays *Excluding Advanced Imaging*	75% after deductible	70% after deductible	50% after deductible
Specialist	75% after deductible	70% after deductible	50% after deductible
	See also Routine Wellness		
Back Pain Program	Designated qualified and enrolled patient receives one-time Health Savings Account (HSA) deposit $45		Not Applicable
Office Surgery	75% after deductible	70% after deductible	50% after deductible
Office Laboratory & X-rays *Excluding Advanced Imaging*	75% after deductible	70% after deductible	50% after deductible
OB/GYN	75% after deductible	70% after deductible	50% after deductible
Smoking Cessation Services	75% after deductible	70% after deductible	50% after deductible
Not covered by office visit:	High cost injections, infusion therapy, outpatient laboratory and X-ray services, chemotherapy, radiation therapy, immunizations, injections, sleep studies, and TMJ services/supplies.		
Second Surgical Opinions	75% after deductible	70% after deductible	50% after deductible
	Benefits will be provided to determine the Medical Necessity of an elective surgical procedure. The second opinion must be made by a board-certified Physician who is affiliated in the appropriate specialty, and who is not an associate of the attending Physician.		
Routine Wellness / Preventive Services Note: All facility charges associated with wellness will be excluded as Non-Network for all Novant facilities. All Novant owned and affiliated health facilities are Non-Network (including for preventive services) except in the case of a medical emergency or in documented situations where the service cannot be performed by another in-network provider. *See Defined Terms, Emergency Medical Condition.*			
	CHS Network	***Other In-Network***	***Non-Network***
Well Child to Age 2	100%; deductible waived		50% after deductible
	Includes Primary or Specialist office visit; laboratory and X-ray services, assessments, vaccines. Standard immunizations / vaccines recommended by the Centers for Disease Control and Prevention (CDC) are covered.		
Routine Adult / Child Age 2+	100%; deductible waived		No Coverage Provided
	Includes Physical or Gynecological exam, laboratory services, X-ray services, immunizations / vaccines / flu shots, health history, developmental assessment, colorectal screening, pap smear, ovarian cancer screenings, PSAs and contraceptive management (Includes FDA approved contraceptive methods / devices and sterilization procedures and education and counseling for women, including intrauterine devices, diaphragms, injectables and hormonal implants, excluding over-the-counter products. Includes injectable contraceptives administered in the physician's office and includes the insertion or removal of a covered device, and any Medically Necessary examination associated with the use		

	of a covered contraceptive device. Oral contraceptives and patches are covered under the Plan's prescription drug benefit.) Gynecologists may perform the Gynecological exam and pap smear, with the balance of the physical exam performed by another Physician. There will be no duplication of services. Vasectomy is covered under this Routine Adult Wellness benefit. The *Patient Protection and Affordable Care Act (PPACA),* as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to copays, coinsurance, or deductibles. * These services include, but are not limited to: Routine physicals; Pediatric wellness examination; Selected preventive, diagnostic, and cancer screenings; and Certain Pediatric Preventive Services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment. These preventive services are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations please visit: ***https://www.healthcare.gov/coverage/preventive-care-benefits/*** Preventive Services for Women without cost share (The following list is not all-inclusive.) • Well-woman visits: Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including prenatal visits billed outside of global obstetric care. • Screening for gestational diabetes. • Testing for human papillomavirus (HPV test) annually or as recommended by physician. • Sterilization procedures and associated services rendered on the same day (Reversal procedures are not covered). • Breastfeeding support and associated supplies and counseling (includes lactation support and counseling provided by a trained provider in conjunction with birth); also includes reasonable cost of the purchase or rental, up to purchase price, of breastfeeding equipment from a network provider, including CMC Gift Shops. Purchase is limited to one per pregnancy and purchase from a retail store is not covered. • Screening and counseling for interpersonal and domestic violence. These preventive services for women are covered based on recommendations of the independent Institute of Medicine and supported by the Health Resources and Services Administration. *Unless otherwise stated in this Summary Plan Description, these services are provided with no cost-sharing for adult women only. See Defined Terms.* The services shown under this section, *"Routine Wellness / Preventive Services,"* are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations, please visit: ***https://www.healthcare.gov/coverage/preventive-care-benefits/*** *A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing to the extent not specified in a recommendation or guideline.	
Bone Mass Measurement	100%; deductible waived	No Coverage Provided
	The Plan covers bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass for certain qualified individuals. A qualified individual is a Plan Participant who has one or more of the following: • estrogen-deficient and at clinical risk of osteoporosis or low bone mass; • radiographic osteopenia in the skeleton; • primary hyperthyroidism;	

	• being monitored to assess the response to, or efficacy of, commonly accepted osteoporosis drug therapies; • history of low-trauma fractures; or • other conditions or on medical therapies known to cause osteoporosis or low bone mass. **One (1) measurement is allowed every two Benefit Years** unless Medically Necessary. Additional measurements will be covered if recommended by a Physician.		
Colonoscopy *Routine**	100%; deductible waived		No Coverage Provided
Colonoscopy *Other than Routine*	100% after deductible	100% after deductible	50% after deductible
	One routine colonoscopy per Benefit Year. *Note: Includes polyp removal during routine colonoscopy when billed as preventive by the provider.		
Mammogram *Routine*	100%; deductible waived		No Coverage Provided
Mammogram *Other than Routine*	100% after deductible	100% after deductible	50% after deductible
	One routine mammogram per Benefit Year.		
PSA *Routine*	100%; deductible waived		No Coverage Provided
PSA *Other than Routine*	100%; after deductible		50% after deductible
	One routine PSA per Benefit Year.		
Nutritional Counseling	100%; deductible waived		50%; deductible waived
	Limited to 6 visits in a Benefit Year Medical Nutritional Counseling, rendered by a licensed health care provider, (in-network when available), as required to provide appropriate guidance and education for diet related conditions or risk factors, including but not limited to diabetes, obesity, high cholesterol and high blood pressure.		
Contraceptive Devices	Covered devices are intrauterine devices, diaphragms, injectables and hormonal implants. Coverage includes the insertion or removal of a covered device, and any Medically Necessary examination associated with the use of a covered contraceptive device.		
Other Services			
	CHS Network	***Other In-Network***	***Non-Network***
Advanced Imaging *MRI, CT, PET scans* *Other than Inpatient*	75% after deductible	75% after CHS deductible	50% after deductible
Allergy Services *Testing / Treatment*	75% after deductible	70% after deductible	50% after deductible
	The Plan will pay for Medically Necessary tests to determine the nature of allergies and for desensitization treatment (allergy "shots") to treat allergies. Test and treatment materials are included.		
Ambulance, Air *Precertification required when non-emergent*	75% after CHS deductible		
	Benefits are for Medically Necessary professional air ambulance services. A charge for this item will be a Covered Charge when services are provided by, and in, an air ambulance traveling from the site of an emergency to a Hospital when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition, unless the Plan Administrator finds a longer trip is Medically Necessary. Non-emergency air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the Injury or Illness, or the pick-up point is inaccessible by land, and such services are precertified. Non-emergency air ambulance services require verification of Medical Necessity or services will not be covered.		
Ambulance, Ground	75% after CHS deductible		
	Benefits are for local Medically Necessary professional ground ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip is Medically Necessary. The Plan covers services in a ground ambulance traveling: • from a Plan Participant's home, scene of an Accident, or site of an emergency to a Hospital;		

	• between Hospitals; and • between a Hospital and a Skilled Nursing Facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition. Benefits may also be provided for ambulance services from a Hospital or Skilled Nursing Facility to a Plan Participant's home when this is Medically Necessary.		
Anesthesia Services	75% after CHS deductible		50% after deductible
Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders (ASD)	As any Covered Medical Expense	As any Covered Medical Expense	As any Covered Medical Expense
	ABA therapy is covered for the treatment of Autism Spectrum Disorders (ASD) provided services are rendered by an appropriately credentialed Physician who is licensed for the provision of such services. Short-Term Therapy other than ABA therapy may be required for treatment of ASD. See also Short-Term Therapy for coverage of physical therapy, occupational therapy, and speech therapy. See also Developmental Dysfunction under Short Term Therapy, and Learning Disorders/Developmental Testing under Medical Benefit Exclusions.		
Chemotherapy / Radiation *and other cancer treatments*	75% after deductible	70% after deductible	50% after deductible
	Benefit includes treatment with radioactive substances as well as materials and services of technicians.		
Chiropractic Services	75% after CHS deductible		50% after deductible
	Benefits limited to Benefit Year maximum of $1,500. Benefits covered when performed by a licensed M.D., D.O. or D.C.; the following services are not within the scope of a chiropractor's scope of practice and are excluded by the Plan: administering or prescribing medicine or drugs; the practice of osteopathy; diagnostic services and surgery.		
Diabetes Care Management *Other than Nutritional Counseling*	75% after deductible	70% after deductible	50% after deductible
Dialysis Services *Other than Inpatient* *Precertification required*	***Fresenius/BMA / RAI***	***Other Network***	***Non-Network***
	75% after CHS deductible	75% after deductible	50% after deductible
	Failure to precertify dialysis will result in associated charges from the first treatment date being denied. Charges for professional fees and services, supplies, medications, labs and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to hemodialysis, home hemodialysis, peritoneal dialysis and hemofiltration.		
	CHS Network	***Other In-Network***	***Non-Network***
Durable Medical Equipment	75% after CHS deductible		50% after deductible
	The Plan has benefits for the rental of Durable Medical Equipment (DME) if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. DME includes, but is not limited to, apnea monitors, glucometers, oxygen equipment, Hospital type beds and wheelchairs.		
Gender Identity Disorder (GID), Non-Surgical and Surgical Precertification is required for surgery.	As any Covered Medical Expense	As any Covered Medical Expense	As any Covered Medical Expense
	Medically Necessary non-surgical medical treatment of gender identity disorder (GID) is covered, including Physician's office visits and Outpatient visits. Medically Necessary surgical treatment of gender identity disorder (GID) is covered as any Covered Medical Expense. Precertification is required for surgery. See Medical Benefit Exclusions and Mental Health and Substance Use Disorders.		
Hearing Exams and Aids	75% after CHS deductible		50% after deductible
	This benefit is limited to $2,500 in any period of 3 Benefit Years. Services are not provided for replacement and/or repair of hearing aids due to theft, misuse, loss, damage or prescription of a different model before 3 Benefit Years have elapsed. The Plan covers a conventional, programmable, digital or other hearing aid to the maximum as stated in the above limitation.		

Home Health Care	75% after deductible	75% after CHS deductible	50% after deductible
	Services and supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. A home health care visit means a visit by a member of a home health care team. Each visit that lasts for a period of 4 hours or less is treated as one home health care visit. If the visit exceeds 4 hours, each period of 4 hours is treated as one visit, and any part of a 4-hour period that remains is treated as one home visit.		
Hospice Care	75% after deductible	70% after deductible	50% after deductible
	Hospice care can provide the physical, psychological, spiritual and social support needed to help terminally ill patients and their families cope with the Illness. Care includes services provided by a Hospice program in the patient's home, a Hospital or a Hospice. These services are covered as long as they are prescribed by a Physician and the covered patient's life expectancy is six months or less. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Employee, covered Spouse and/or covered Dependent Children) are covered. Bereavement services must be furnished within six months following the patient's death.		
Infertility Services - *Diagnosis*	100% after deductible	As any office visit	50% after deductible
Infertility Services - *Treatment*	100% after deductible	No Coverage Provided*****	No Coverage Provided
	Infertility Services for diagnosis and treatment are available to covered Employee and covered Spouse only. **Benefits for Diagnosis and Treatment combined limited to Lifetime Maximum of $25,000. Lifetime Maximum for Prescription drugs for Infertility limited to $10,000.** ***** Benefits are provided for certain services related to the diagnosis, treatment and correction of underlying causes of infertility for all covered Employees and covered Spouses. Such services include, but are not limited to artificial insemination, in-vitro fertilization (IVF) ovum or embryo placement, intracytoplasmic sperm insemination (ICSI) and associated services. To be eligible for treatment benefits, all services/treatment must be provided at Carolinas Medical Center by Carolinas HealthCare System Reproductive Medicine and Infertility.***** Benefits are available after the covered Employee has been employed by CHS for one or more years. Non-Network exceptions do not apply to treatment benefits WITH THE EXCEPTION of those members whose primary residence is located fifty (50) miles or more from the Carolinas HealthCare System Reproductive Medicine and Infertility and who receive such treatment benefits from any CHS Provider or Network Provider / infertility center.♦ Treatment benefits for such members shall be paid at the CHS Provider level as described above. ♦Notice: Presbyterian and / or Novant are EXCLUDED for all Infertility Services at all times. The Plan does not pay for donor eggs and/or sperm, infertility or reduced infertility that results from a prior sterilization procedure, or when infertility or reduced infertility is the result of a normal physiological change such as menopause. A Plan Participant who has had a prior sterilization procedure is not eligible for infertility benefits. See also Infertility exclusion and Surrogacy exclusion under Medical Benefit Exclusions.		
Injectables and Infusion Therapy *See also Office Visit or Allergy Services or Home Infusion Therapy*	75% after CHS deductible		50% after deductible
	See also Office Visit or Allergy Services or Home Infusion Therapy Certain Prescription Drugs may be purchased through CHS Specialty Pharmacy. See Prescription Drug Benefits, Limitations and Exclusions for details.		
Home Infusion Therapy	Home infusion therapy is covered for the administration of prescription drugs directly into a body organ or cavity, or via intravenous, intra-spinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a Physician. These services must be provided under the supervision of an RN or LPN. Covered services		

		are: • professional services of an RN or LPN, • specimen collection, laboratory testing and analysis, • patient and family education, • delivery of drugs and supplies, • management of emergencies arising from home infusion therapy, and • prescribed drugs related to infusion services. *See also Prescription Drug Benefits, Specialty Drugs.*		
Laboratory and X-Ray Services *Outpatient*		75% after CHS deductible		50% after deductible
Medical Supplies		75% after CHS deductible		50% after deductible
Maternity Care Services: Facility / Birthing Center				
Facility / Birthing Center		70% after deductible	60% after deductible	50% after deductible
Outpatient Diagnostic, Independent		70% after deductible	60% after deductible	50% after deductible
Other Outpatient		70% after deductible	60% after deductible	50% after deductible
Maternity Care Services: Physician				
Pregnancy/ Prenatal visit		75% after CHS deductible		50% after deductible
Newborn Nursery	*Well Baby*	75% after deductible	70% after deductible	50% after deductible
	Sick Baby	75% after deductible	70% after deductible	50% after deductible
		See also SmartStarts. Charges for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Employee, covered Spouse and covered Dependent Child. (No coverage for newborn of Dependent Child) Maternity Care Services for all covered Adult Women, including Dependent daughters, include Prenatal Care with no cost-share as required by PPACA, if billed independently. See Routine Wellness/Preventive Services. See Defined Terms.		
Newborn Nursery: Facility - *Well Baby / Sick Baby*		70% after deductible	60% after deductible	50% after deductible
		Routine newborn nursery and Physician care while the newborn is Hospital-confined typically includes room and board along with ancillary charges for the normal care of a newborn. Charges in these circumstances will be applied to the Plan of the mother. Non-routine newborn nursery and Physician care will not be eligible for reimbursement under the Plan until the newborn is enrolled as a Dependent under the Plan enrollment provisions. For details about enrolling newborn children, please see "Enrollment Requirements for Newborn Children," the Special Enrollment provisions, and "Open Enrollment," all in the Enrollment section.		
Mental Health and Substance Use Disorders Services *Note*: Requires precertification by CBHA. See Appendix A for details.				
		CHS Network	***Other In-Network & CBHA***	***Non-Network***
Inpatient		70% after deductible	60% after deductible	50% after deductible
Outpatient Facility		70% after deductible	60% after deductible	50% after deductible
Outpatient Physician		75% after deductible	70% after deductible	50% after deductible
		Psychiatrists (M.D.), psychologists (Ph.D.) or Masters of Social Work (M.S.W.) may bill the plan directly. Other licensed mental health practitioners may be asked to file claims under the direction of these professionals, depending on credentialing guidelines.		
		CHS Network	***Other In-Network***	***Non-Network***
Obesity, Non-Surgical Medical Treatment		As any office visit	As any office visit	As any office visit
		Medically Necessary Non-surgical treatment of obesity is covered. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered.		
Obesity, Surgical Treatment		As any expense	As any expense	As any expense
		Bariatric Surgery is provided by the Plan if the Plan Participant meets the Bariatric Surgery Acceptance Criteria of the Plan. Some of the criteria are:		

	• The surgery is determined to be Medically Necessary. • The Plan Participant is at least age 18. • The Plan Participant has a Body Mass Index (BMI) between 35 and 60, or if the BMI is between 35 and 40, the Plan Participant must also have at least one associated medical problem. • The Plan Participant is a non-smoker. • Testing used for authorization purposes must be current within one year. • Nutritional/dietary assessment and specific follow-up plans by a Registered Dietician. • Psychological evaluation by a professional of the patient's ability to understand and follow a mental health program. IMPORTANT: The Plan does not cover repeat bariatric surgery, reoperation, or elective reversal. However, the Plan covers surgical reversal (i.e., takedown) of bariatric surgery as Medically Necessary when the individual develops complications from the original surgery such as stricture or obstruction. The Plan does not cover cost of medically supervised weight loss programs or exercise regimes. Note**:** Office visits for Obesity are covered as any other Physician office visit.		
Orthotics	75% after CHS deductible		50% after deductible
	Limited to 1 pair of custom molded inserts per Benefit Year. Orthotics are covered for the initial purchase and fitting of an appliance designed for the support of weak or ineffective joints or muscles as a result of a disabling congenital condition or an Injury or Illness. Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.		
Pathology Services	75% after CHS deductible		50% after deductible
Private Duty Nursing	75% after deductible	70% after deductible	50% after deductible
	Private duty nursing is covered when performed by a licensed nurse (R.N., L.P.N. or L.V.N.) and only when care is Medically Necessary, is not Custodial in nature and the Hospital's Intensive Care Unit is filled, or the Hospital has no Intensive Care Unit. The only charges covered for Outpatient nursing care are those shown under Home Health Care. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.		
Prosthetics	75% after CHS deductible		50% after deductible
	Benefit covers the initial purchase and fitting of a fitted artificial device to replace or augment a missing or impaired part of the body. Prosthetic devices include, but are not limited to, artificial limbs, breast prosthesis, cochlear implants, dental restorations and implanted lenses after cataract surgery. Dental restorations will only be considered as defined under *Additional Services Covered Under the Medical Benefits – Dental Services*. Repair and replacement of a device will be considered when Medically Necessary, or when due to growth. Replacements will not be made more than once every 5 years, and will not be made because the device is lost, misplaced or stolen. Prosthetics do not include dentures, eyeglasses, orthopedic or corrective shoes, or any other supportive devices for the feet.		
Short-Term Therapy			
Cardiac Rehabilitation			
Facility	70% after deductible	60% after deductible	50% after deductible
Physician	75% after deductible	70% after deductible	50% after deductible
	Benefits limited to Benefit Year maximum of 90 visits. Cardiac rehabilitation is covered as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.		
Developmental Dysfunction*			

Facility	70% after deductible	60% after deductible	50% after deductible
Physician	75% after CHS deductible		50% after deductible
	Benefits limited to Benefit Year maximum of 130 visits.* Developmental dysfunction therapy includes delays but excludes learning disabilities. See Medical Benefits Exclusions. *This benefit includes visits for Occupational, Physical, Pulmonary, Speech and Respiratory therapies if / when one of the maximums listed below is exhausted. See also Applied Behavioral Analysis (ABA) Therapy for Autism Spectrum Disorders (ASD)		
Occupational, Physical, Pulmonary, Respiratory, and Speech			
Facility	70% after deductible	60% after deductible	50% after deductible
Physician	75% after CHS deductible		50% after deductible
Occupational – Limited to Benefit Year maximum of 20 visits	Occupational therapy is covered when performed by a licensed occupational therapist or a Physician working within the scope of his/her license. Therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.		
Physical – Limited to Benefit Year maximum of 30 visits	Physical therapy is covered when performed by a licensed physical therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency, and duration, and for conditions that are subject to significant improvement through short-term therapy.		
Pulmonary – Limited to Benefit Year maximum of 50 visits	Pulmonary therapy is covered when performed by a licensed therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency, and duration, and for conditions that are subject to significant improvement through short-term therapy.		
Respiratory – Limited to Benefit Year maximum of 50 visits	Respiratory therapy is covered when performed by a licensed respiratory therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency, and duration, and for conditions that are subject to significant improvement through short-term therapy.		
Speech – Limited to Benefit Year maximum of 20 visits	Speech therapy is covered when performed by a licensed speech therapist or a Physician working within the scope of his/her license; therapy must be ordered by a Physician: a) for speech disorders; b) following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or c) to restore speech to a person who has lost existing speech function as a result of injury or an illness that is other than a learning or mental disorder.		
Skilled Nursing Facility	75% after CHS deductible		
	Benefits limited to Lifetime maximum of 100 days. Benefits are payable if and when the patient is confined as a bed patient in the facility; the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and the attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. Covered charges for a Plan Participant's care in these facilities are limited to the facility's semiprivate room rate.		
Telemedicine	As any office visit	As any office visit	As any office visit
TMJ *Surgical and Non-Surgical*	75% after deductible	75% after CHS deductible	75% after CHS deductible
Transplant Services *Precertification required*	**Approved / Designated Facility**		**Non-Approved / Non-Designated Facility**
	100% after CHS deductible		50% after deductible
	MedCost Medical Management must be notified PRIOR to a Transplant evaluation. All Transplant Services MUST be precertified. Failure to precertify may result in a 50% reduction in eligible charges. All Transplant Services REQUIRE Case Management. If you choose not to participate in Case Management, eligible charges will be reduced by 50%. Human organ and tissue transplants are covered except those classified as "Experimental and/or Investigational." *Travel and lodging will be paid by the Plan for the patient and one companion or caregiver (for both parents or for both guardians if the patient is a minor), up to a		

	Lifetime maximum of $5,000. Travel must be to a Designated Transplant Provider that is more than 60 miles from the patient's home. The Plan will pay for tissue typing, surgical procedure, storage expenses and transportation costs directly related to the donation of a human organ or human tissue used in a covered Transplant procedure. If the donor has other coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. If a Plan Participant wishes to be a donor, the Plan will cover donor charges only if the recipient is also a Plan Participant. * Charges for the following are not covered: • mileage for sightseeing or visits to friends / relatives; • alcohol; • clothing; • entertainment (i.e., movies or rentals, visits to museums, mileage for sightseeing, compact discs, games, etc.); • expenses for persons other than the patient and his/her covered companion or caregiver; • expenses for lodging when member or companion is staying with a relative or friend; • gift cards; • groceries (i.e., grocery stores, Wal-Mart, K-Mart, etc.); • laundry service / supplies; • non-legible receipts (i.e., food or lodging); • paper products (i.e., paper plates, paper towels, napkins, etc.); • parking fees incurred other than at hotel / motel or Hospital; • personal care services (i.e., massage, spa, hair care services, etc.); • personal hygiene items (i.e., toothbrush, deodorant, etc.); • personal services (i.e., child care, house sitting, kennel care, etc.); • shoes / slippers; • souvenirs (i.e., T-shirts, sweatshirts, toys, etc.); • telephone bills / calls / phone cards; • tobacco; and • valet parking		
	CHS Network	***Other In-Network***	***Non-Network***
Wig Therapy	75% after CHS deductible		50% after deductible
	Wig following cancer treatment covered. **Benefits limited to Lifetime maximum of $250.**		
All Other Covered Services	75% after deductible	70% after deductible	50% after deductible
Additional Services Covered Under the Medical Benefits			
Clinical Trials	The Plan provides benefits for participation in Phase IV clinical trials (*see below). Coverage is provided only for Medically Necessary costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable to non-investigational alternatives. In addition, the trial must: • involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists; • be approved by centers or groups funded by the National Institute of Health (NIH), the Federal Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC) the Agency for Health Care Research and Quality, the Department of Defense (DOD) or the Veterans Administration (VA); • be conducted in a setting and by personnel of high expertise based on training, experience and patient volume. ***IMPORTANT NOTE:** For additional information about clinical trials (including clinical trials for treatment of cancer) that may be covered under this Plan, please*		

	refer to "Experimental, Investigational or not Medically Necessary" under Medical Benefits Exclusions and "Qualified Clinical Trial" under Defined Terms.
Contact Lenses or Glasses after Cataract Surgery	Initial Contact Lenses or Glasses required: • following cataract surgery • as a result of surgery or Injury to the lens of the eye; • for the treatment of infantile glaucoma; • to treat keratoconus; • to keep eyes moist (prescribed when normal tearing is inadequate); • to reduce an irregularity of the cornea, excluding astigmatism.
Dental Services	The Plan will pay for services and supplies for a Dental Accident involving sound, natural, permanent adult teeth if the services are performed or supplies provided as part of the initial emergency treatment for the Accident, and to the extent that most closely approximates pre-Accident form and function. Additional benefits for final restoration for the teeth originally involved in the dental accident may be available under the prosthetic benefit (see also Prosthetic benefit for details), as long as the following conditions are met: a) Pre-treatment estimate must be completed to define the entire treatment plan proposed and estimated cost; b) Dentist verification that the proposed treatment provides restoration that most closely approximates the pre-accident form and function; c) Verification that there is no duplication of coverage under any other benefit or plan; and d) The condition or accident is severe enough to warrant additional restorative procedures, outside of the initial emergency treatment. When Medically Necessary, replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment will be covered. For the following conditions, the Plan will provide benefits for services for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw: • accidental Injury of natural teeth, jaw, cheek, lips, tongue, roof and floor of the mouth; • congenital deformity, including cleft lip and cleft palate; • disease due to infection or tumor, including cysts and exostosis; • TMJ disease. *Note: Services performed by an oral surgeon will be paid at the Network level of benefits when the services are Medically Necessary and approved by the Claims Administrator.* In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a Hospital or Ambulatory Surgical Center. These benefits are only available to: • covered Dependent children under age 9; • persons with serious mental or physical conditions; • persons with significant behavioral problems. The treating Physician must certify that the person's age, condition or problem(s) requires hospitalization for general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for the surgery, are not covered unless specifically stated by the Plan. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.
Family Therapy / Counseling	Family Therapy/Counseling is considered an eligible expense when provided by a licensed mental health practitioner. *See Appendix A.*
Genetic Testing	Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

	Genetic testing is considered Medically Necessary (and therefore covered) based on the diagnosis, provided: • a person has symptoms or signs of a genetically-linked inheritable disease; or • the testing is performed as part of oncology treatment. Genetic testing requires documentation of Medical Necessity via medical records or a letter of Medical Necessity if: • it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or • the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer reviewed, evidence-based, scientific literature to directly impact treatment options as outlined in the letter of Medical Necessity noted above; or • in accordance with the guidelines and recommendations established under PPACA for preventive services for women with no cost-share. If genetic testing is determined to be Medically Necessary and meets the criteria outlined above, genetic counseling may be covered. Genetic counseling is limited to 3 visits per Benefit Year.
Laboratory Studies & **Diagnostic X-rays**	Laboratory studies and Diagnostic X-rays that are not Experimental and / or Investigational and their interpretation.
Reconstructive Surgery	Covered Charges are: • surgical correction of a congenital anomaly in a covered Dependent child; • treatment of an Accidental bodily Injury; and • reconstructive breast surgery following mastectomy. This mammoplasty coverage, in compliance with the *Women's Health and Cancer Rights Act of 1998*, will include reimbursement for: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient. *See also Medical Benefits Exclusions, "Prophylactic mastectomy and hysterectomy surgeries."*
Sleep Studies	Sleep studies are covered as any Outpatient lab or independent lab when determined to be Medically Necessary.
Sterilization Procedures	Sterilization procedures are covered for a covered Employee or covered spouse as any expense unless otherwise noted in the SPD. Reversal procedures are not covered.
Termination of Pregnancy	Termination of Pregnancy, whether elective or therapeutic, is available through the first 16 weeks of a pregnancy for any health Plan Participant. Exceptions may be permitted if severe congenital anomalies are discovered later than 16 weeks.

Prescription Drug Benefits

*Plan Participants will be required to meet an Annual Deductible first, then the below listed Copays will apply (except for Affordable Care Act Preventive Drug List and the CHS Preventive List).

Prescription Drug cost-sharing accumulates toward the Plan's overall CHS Out-of-Pocket Maximum.

Prescription Drug Tiers	CMC Rx Retail Pharmacies (30-day supply)	Community Retail Pharmacies (30-day supply)	CarolinaCARE Mail Service (30-day supply)	CarolinaCARE Mail Service (90-day supply)
[1,2]Affordable Care Act Preventive Drug List (ACA)	$0 Copay[1]	$0 Copay[1]	$0 Copay	$0 Copay
[1]Carolinas HealthCare System Preventive List	$4 Copay[1]	$15 Copay[1]	$4 Copay	$12 Copay
	Meet Annual CHS Deductible first then:	Meet Annual CHS Deductible first then:	Meet Annual CHS Deductible first then:	Meet Annual CHS Deductible first then:

[3,4]Generic	$10 Copay	$15 Copay	$10 Copay	$25 Copay
[3,4]Preferred Brand	25% coinsurance not less than $35 or more than $45	30% coinsurance not less than $35 or more than $100	$35 Copay	$85 Copay
[3,4]Non-Preferred Brand (Tier 4 Medications – PA required – see below)	40% coinsurance not less than $50 or more than $150	50% coinsurance not less than $60 or more than $250	40% coinsurance not less than $50 or more than $150	40% coinsurance not less than $125 or more than $375
[4]Specialty Drugs (self-injectables administered at home, oral chemo agents, infertility treatment)	20% coinsurance not more than $125	Not Applicable	20% coinsurance not more than $125	Not Applicable
Step Care Therapy Programs	Therapies for depression, allergies, asthma, and COPD should begin with a Generic Drug. Refer to the Medication Cost Guide at **www.carolinacarerx.org**			

*NOTE: After the deductible is met, Copays and coinsurance apply. The Copays and coinsurance will apply to the Out-of-Pocket amount until the out-of-pocket limit is reached. Once the out-of-pocket limit is reached, prescriptions will be paid at 100%.

[1]After maximum of one fill for ACA and preventive maintenance medication at retail, member pays full cost unless transferred to CarolinaCARE.

[2] Includes certain aspirin, bowel preparations, fluoride, folic acid, iron, smoking cessation, breast and prostate cancer prevention, and contraceptive products.

[3]After deductible is met, one fill allowed at retail before transfer to CarolinaCARE.

[4] Specialty drugs: See CHS Specialty Pharmacy list. CHS Specialty medications are available at CarolinaCARE. Exception: Fertility Specialty drugs are available at CMC Rx MCP location. Other exceptions may apply to limited distribution drugs.

CarolinaCARE – Telephone number: 704-512-6800 or 866-697-6800.
OptumRx – Telephone number: 877-633-4461.

PRIOR AUTHORIZATION
Tier 4 Medications

A Prior Authorization (PA) is required for Brand name drugs for which an approved Generic equivalent is available.

NO COVERAGE WITHOUT PRIOR AUTHORIZATION.

When a Prior Authorization is approved for a Tier 4 medication while the Plan Participant is in the deductible phase of the Plan:

- Plan Participant pays 100% of drug cost
- Drug expense applies to both the Deductible and the Out-of-Pocket Maximum.

When a Prior Authorization is approved for a Tier 4 medication AFTER the deductible is met, the Plan Participant pays Tier 3 (non-preferred brand) coinsurance.

- Plan Participant expense applies toward the Out-of-Pocket Maximum.
  - CarolinaCARE: 40% of drug cost with a $50 minimum / $150 maximum for 30 day supply or $125 minimum / $375 maximum for 90 day supply
  - Retail: 50% of drug cost with a $60 minimum / $250 maximum for 30 day supply

When a PA is NOT approved for a Tier 4 medication, the Plan Participant will pay 100% of the cost of the medication as a cash payment. The prescription claim does not process through the prescription benefit, and the expense will not apply to the Deductible or the Out-of-Pocket Maximum.

Gender Identity Disorder: Prescription Drugs for treatment, including hormone replacement therapy, are covered.

Please refer to remainder of Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions.

GENERAL PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. The Plan Administrator is responsible for determining and providing Plan benefits, not the Third Party Administrator.

ELIGIBILITY

Eligible Classes of Employees
All Employees of the Employer

Eligibility Requirements for Employee Coverage
A person is eligible for Employee coverage from the first day that he or she:

1. Is a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she has standard hours of at least 30 hours per week and is on the regular payroll of the Employer (excluding Temporary Employees).

2. Is a Part-time Employee of the Employer. An Employee is considered to be Part-Time if he or she has standard hours of at least 24 hours per week and is on the regular payroll of the Employer (excluding Temporary Employees). Effective January 1, 2016, part-time Employees working 16 to 23 hours weekly are not eligible for coverage under the Plan.

3. Is in a class eligible for coverage.

4. Completes the employment Waiting Period* of 30 days as an Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. Upon completing the Waiting Period, coverage will begin the first day of the following month.

*Students enrolled as medical residents, in the pastoral residency program, or in the School of Anesthesiology, as well as Employees transferring from one of the leased or managed facilities of CHS, do not have to complete the Waiting Period.

Acquisitions
When Employees become eligible for coverage under the Plan due to a Company acquisition, the Waiting Period will be waived for Employees and their Dependents who meet the definition of an eligible Employee and who were covered under the acquired company's medical plan at the time of the acquisition (had already satisfied the Waiting Period of the acquired company's medical plan or the Waiting Period as defined by the LiveWELL Health Plan). Coverage will become effective on the date of acquisition or agreed upon commencement date if later.

Credit will be given for prior medical deductibles and out-of-pocket expenses accumulated under the acquired company's medical plan. Such Employees and/or Dependents must be identified by the Plan.

If the Waiting Period of the acquired company's plan has not been fully satisfied, credit toward this Plan's Waiting Period will be given for time applied toward satisfaction of the acquired company's plan Waiting Period.

Eligible Classes of Dependents
A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

A Dependent is any one of the following persons:

1. A Covered Employee's Spouse
"Spouse" shall mean a person to whom you are married. The Employer may require documentation proving a marital relationship. *Note*: The Plan does not offer coverage to a domestic partner.

2. Children from Birth to the Limiting Age of 26 Years
Dependent children under the age of 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status or the amount of financial support from the parent.

If both parents of the eligible Dependent child have employer sponsored coverage, the Dependent child may enroll in either plan. Neither plan can deny enrollment.

Coverage will end upon the end of the month during which the Dependent child's 26th birthday occurs, or in the event of the covered Employee's termination and refusal of, or loss of, COBRA continuation, whichever occurs first.

The term "children" shall include:

- natural children.
- adopted children, or children placed with a covered Employee in anticipation of adoption.
- Foster Children.
- step-children, as long as a natural parent remains married to the Employee and the natural parent resides in the Employee's household.
- a child for whom the covered Employee has legal guardianship and who lives with the covered Employee in a regular parent/child relationship. A parent/child relationship does not exist if either parent of the child also lives in the covered Employee's home.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child who the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

A **Qualified Medical Child Support Order** (QMCSO) means any judgment, decree or order (including approval or settlement agreement) issued by a court of competent jurisdiction. A QMCSO is a court order that creates or recognizes the right of a covered person's child (called an alternate recipient in the law) to receive benefits under the Plan. To be considered a QMCSO, the medical child support order must clearly specify the following information:

- the name and last known mailing address of the covered person and the name and mailing address of each child covered by the order;
- a reasonable description of the type of coverage to be provided by the Plan for each such child, or the manner in which the type of coverage is to be determined;
- the period to which the order applies; and
- each plan to which the order applies.

The Plan Sponsor and Plan Administrator is responsible for establishing reasonable, written procedures for determining if the court order is a QMCSO. The Plan Sponsor and Plan Administrator must notify the Covered Person and the child that a court order has been received and within a reasonable time inform the Covered Person and the child whether or not the court order is a QMCSO. If the court order is determined to be a QMCSO, the child is an alternate recipient and considered a beneficiary under the Plan. Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the child, the child's custodial parent or other designated representative, or if benefits are assigned, to the provider of care.

The court order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. If a state has paid for medical services for the child under Medicaid for which the Plan was liable, the state may seek to recover those amounts paid from the Plan.

3. A Covered Dependent Child Who Is Totally Disabled

Under the Limiting Age

If a covered child is Totally Disabled before reaching the limiting age for an eligible Dependent, his or her coverage will be continued if it would otherwise end due to attainment of the limiting age.

After reaching the Limiting Age

The child's coverage will be continued after reaching the limiting age as long as: (a) he or she remains Totally Disabled; (b) he or she remains unmarried and chiefly dependent on the covered Employee for support; (c) the covered Employee remains covered under the Plan; (d) the part of the Plan providing his or her coverage remains in force; and (e) the covered Employee continues to pay any part of the cost required for the child's coverage.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Eligibility Requirements for Dependent Coverage
A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

These persons are excluded as Dependents:
- other individuals living in the covered Employee's home, but who are not eligible as defined;
- the legally separated Spouse of the Employee under the laws of the state where the covered Employee lives;
- the divorced former Spouse of the covered Employee;
- any Spouse who is on active duty in any military service of any country; or
- any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

FUNDING

Cost of the Plan: Carolinas HealthCare System shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

Employees contribute toward the cost of all coverage under the Plan through payroll deductions. Premium contributions for health coverage are allowed on a pre-tax basis in conjunction with a Section 125 plan offered by the Company. Section 125 plan elections are binding for one year unless a change recognized by the Section 125 plan occurs. Note that the option to drop coverage and thereby decrease premium contributions at a time other than the scheduled Section 125 plan enrollment period may be limited to a change recognized by the Company's Section 125 plan. Contact the Company's Human Resources Department for additional information.

ENROLLMENT

Enrollment Requirements
An Employee must enroll for coverage by filling out and signing an enrollment application that includes the appropriate payroll deduction authorization. If the Employee wants coverage for his/her Dependent(s), he/she is required to enroll for Dependent coverage also. The completed enrollment form must be received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

Enrollment Requirements for Newborn Children
A newborn child of a Covered Employee is not automatically enrolled in this Plan. For coverage to begin at birth, the child must be enrolled in the Plan within 31 days following its birth. This means an enrollment form on behalf of the newborn is required to be completed to ensure accurate information and timely claims payments, and must be received by Human Resources within 31 days following the birth of the child. If the newborn child is not enrolled in this Plan within 31 days following its birth, there will be no payment from the Plan for expenses of the newborn and the covered Employee will be responsible for all expenses of the newborn. Such a newborn child will be permitted to be enrolled in the Plan in accordance with the Special Enrollment provisions (Qualified Status Change, if any) with coverage effective as of the date of birth, or, the next Open Enrollment.

Qualified Status Change Rights
Federal law provides Qualified Status Change provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility, including involuntary loss of Medicaid, for that other coverage (or if the Employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

Involuntary loss of coverage under a state sponsored health plan, including Medicaid, or the State Children's Health Insurance Program (SCHIP) entitles an eligible person to the Qualified Status Change provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Coverage under this Plan must be requested within 60 days after the loss of Medicaid or SCHIP.

The Plan will give Employees and/or Dependents who are eligible but not enrolled for coverage under the Plan the opportunity to enroll when the Employee and / or Dependent is determined to be eligible for premium assistance under Medicaid or the State Children's Health Insurance Program (SCHIP). Coverage under this Plan must be requested within 60 days of being determined to be eligible for the premium assistance.

The Qualified Status Change rules are described in more detail below. To request a Qualified Status Change or obtain more information, contact your Employee Benefits Department.

Qualified Status Change Periods
The Enrollment Date for anyone who enrolls under a Qualified Status Change is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. Individuals losing other coverage creating a Qualified Status Change
An Employee or Dependent who is eligible but not enrolled in this Plan may enroll if loss of eligibility for coverage is due to ***each*** of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage [(including Medicaid or State Children's Health Insurance Program (SCHIP)] at the time coverage under this Plan was previously offered to the individual.

- If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

- The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated.

- The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. The employee or dependent must request enrollment in this Plan not later than 60 days from the date of loss of eligibility for Medicaid or SCHIP. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

- For purposes of these rules, a loss of eligibility occurs if:

    - The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

    - The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

- The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

- The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

- The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Note: If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Qualified Status Change right.

2. Dependent beneficiaries

If:

- The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

- A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Qualified Status Change in order for his eligible Dependents to enroll.

The Dependent Qualified Status Change is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Qualified Status Change, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Qualified Status Change will be effective:

- in the case of marriage, the date of marriage;
- in the case of a Dependent's birth, as of the date of birth; or
- in the case of a Dependent's adoption or placement for adoption, the date of the adoption or the placement for adoption.

Open Enrollment

Every year, at a time decided by the Employer, there will be an Open Enrollment period. Covered Employees will be able to change some of their benefit decisions based on which coverage and benefits are right for them and their Dependents, if any.

During the Open Enrollment period an Employee will be able to enroll in the Plan. In no event will any Employee be allowed to enroll for coverage under the Plan during the Open Enrollment period unless he or she has completed all of the Eligibility Requirements as set out on a previous page.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect and binding until the next following January 1st unless a person experiences an event that qualified as a Qualified Status Change under the provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA*) or an event that allows the person to change his or her election under a Section 125 plan (if the Employer offers a Section 125 plan).

A Plan Participant who fails to make an election during Open Enrollment will automatically retain his or her present coverage. Plan Participants will receive detailed information regarding Open Enrollment from their Employer.

TERMINATION OF COVERAGE

When Employee Coverage Terminates
Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage).

- The date the Plan is terminated.
- The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled *Continuation Coverage Rights under COBRA*.

Non-FMLA Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff
A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff (provided the Plan does not terminate during this period). Refer to the *CHS Policy and Procedural Manual* or contact your Employee Benefits Department.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

The Plan reserves the right to choose a different plan for continuing coverage; however, any such plan will not be discriminatory.

Continuation during Family and Medical Leave (FMLA)
Regardless of the established leave policies mentioned above, if the Employer is subject to FMLA regulations, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

The following is a brief description of the main provisions of the *Family and Medical Leave Act of 1993*. It does not detail every provision of the Act. Employees should contact their Human Resources Department or the Plan Administrator for additional information or a copy of the Company's written policy regarding compliance with the *Family and Medical Leave Act*.

The Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 12 weeks during a qualified leave of absence, which includes any of the following:

- The birth of a child, or placement of a child for adoption or foster care;
- To care for a spouse, child, or parent with a serious health condition;
- As a medical leave when the Employee is unable to work due to a serious medical condition; or
- Any qualifying exigency (i.e., emergency or necessity) arising out of the fact that the Employee's spouse, son daughter or parent is a military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

Additionally, the Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 26 weeks in a single 12-month period during a leave of absence to care for a service member with a serious injury or illness incurred in the line of duty. The covered Employee must be a spouse, son, daughter, parent or next of kin of the injured or ill service member.

To be eligible, the covered Employee must have been employed with the Company for at least 12 months, must have worked at least 1250 hours during the 12 months preceding the leave, and must be employed at a worksite where 50 or more employees are employed within 75 miles of that worksite*. The 12 months an Employee must have been employed do not have to be consecutive. Whether an Employee has worked at least 1250 hours during the preceding 12 months must be determined as of the date the leave is to begin. (Employees who are exempt from the *Fair Labor Standards Acts'* minimum wage and overtime requirements, and who have been employed for at least 12 months are presumed to have met their 1250-hour eligibility.)

During an FMLA qualified leave of absence, the Employee's benefits under the Plan may continue as if he or she was actively at work. The Employee must continue to pay any part of the cost he or she was required to pay before the leave began.

Note: The Employer makes the determination as to whether the Company is subject to FMLA regulations, and whether or not the Employee meets the eligibility requirements for leave under FMLA. Employees should contact their Human Resources Department with questions related to FMLA.

Rehiring a Terminated Employee
A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or her termination date will not be required to satisfy the Employer's Waiting Period, if any. All other previously covered Employees who are reinstated will be treated as new hires and will be required to satisfy all eligibility and enrollment requirements. An Employee returning to work directly from COBRA coverage will not be required to satisfy the Employer's Waiting Period, if any. Refer to the Human Resources Department regarding any questions about rehire provisions.

Workers in Transition (WIT) and Employees with 'Disabled' status should refer to the CHS Policy and Procedural Manual or contact the Employee Benefits Department regarding Waiting Periods and eligibility.

Upon completion of residency and signature of continuation contract, coverage continues under the Plan during hiatus for up to six (6) months, with coverage continuing under the Plan upon return to work with the Employer. Please see Human Resources for details should extenuating circumstances occur.

Employees on Military Leave (USERRA)
In any case in which an Employee has coverage under the Plan, and such Employee is absent from such position of employment by reason of service in the uniformed services, the Employee may elect to continue coverage under the Plan as provided in this section. The maximum period of coverage of the Employee and the Employee's Dependents under such an election shall be the lesser of:

- The 24 month period beginning on the date on which the Employee's absence begins; or
- The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under the *Uniformed Services Employment and Re-Employment Rights Act (USERRA)*.

An Employee who elects to continue Plan coverage under this section must pay 102% of his or her normal premium under the Plan. Except that, in the case of an Employee who performs service in the uniformed services for less than 31 days, such Employee will pay his or her normal contribution for the 31 days.

An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Except as provided in paragraph #4 below, upon re-employment and reinstatement of coverage no new exclusion or waiting period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This paragraph applies to the Employee who is re-employed and to an individual who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.

Paragraph #3 above shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

When Dependent Coverage Terminates
A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage).

- The date the Plan or Dependent coverage under the Plan is terminated.
- The end of the pay period in which the Employee's coverage under the Plan terminates for any reason including death.
- The end of the pay period in which a covered Spouse loses coverage due to loss of dependency status.
- The end of the pay period in which a Dependent child ceases to be a Dependent as defined by the Plan, or with respect to a Dependent child's 26th birthday, the end of the month during which the Dependent child's 26th birthday occurs;
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- With respect to a child required to be covered under the terms of a court or administrative order, the earlier of the date the order is no longer in effect, or the date the child becomes covered under another comparable plan of health benefits.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled *Continuation Coverage Rights under COBRA*.

The Health Savings Account (HSA) Component
This section is intended to provide the Participant with information about the Health Savings Account (HSA) component of the Consumer Driven High Deductible Plan with Health Savings Account (HSA). The Participant must be covered under the Plan in order to participate in the HSA; however, this section will outline the HSA component and not the Plan itself. For benefits and coverage information, please refer to the *Schedule of Benefits*.

The HSA provides the Participant with a means of paying for certain out-of-pocket expenses, such as Deductibles and coinsurance amounts, not reimbursed by the Plan. These expenses are paid from funds collected through pre-tax payroll contributions to the HSA made by the Participant. The HSA is not an employer-sponsored Employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee / custodian to each electing Participant and are not a part of this Plan.

Eligibility to Participate in the HSA Component
A Participant must be covered under the Plan in order to be eligible to participate in the HSA. To meet HSA eligibility requirements, the Participant must Not:

- Be covered under any non-high deductible group health plan or "general purpose" Flexible Spending Account (FSA) either through the Employee's own coverage or through any coverage provided through their Spouse's employment;
  Note: *A "general purpose" FSA is an FSA that provides more than preventive care, dental care or vision care coverage. ("Limited purpose" FSA is permitted.)*
- Be eligible to enroll in Medicare;
- Be claimed as a Dependent on another person's tax return.

Contributions to the HSA
Contributions can be made to the HSA upon enrollment in the Plan and upon submitting a CHS Benefits Enrollment/Change Form /Election Form/Salary Reduction Agreement to the Benefits Administration Department. The annual contribution for a Participant's HSA benefits equals the annual benefit amount elected by the Participant and will be prorated for the number of months in which the Participant is HSA eligible. No further contributions may be made to the HSA once participation in the Plan has terminated.

The maximum amounts allowed for tax-free, single and family HSA contributions are mandated by the Internal Revenue Service (IRS). Additional tax-free contribution amounts may be allowed for Participants between ages of 55 and Medicare entitlement age. Amounts contributed to the HSA in excess of the federally mandated limits will be subject to taxation.

Note: Current federally mandated contribution limits can be found on the IRS website at ***www.irs.gov.***

Qualified Health Expenses under the HSA Component
Contributions to a Participant's HSA will typically be used to pay for the deductible and coinsurance amounts of eligible expenses that a Participant, or a Participant's eligible Dependent(s), would have to pay under the Plan. In some instances, care that is not eligible for coverage under the High Deductible Plan may be reimbursable by the HSA (under Section 213(d) of the Internal Revenue Code).

Certain "non-qualified health expenses" may also be reimbursable by the HSA; however, such reimbursements will generally be subject to taxation unless an exception applies (as stated under Section 213(d) of the Internal Revenue Code). Participants should keep receipts and medical records to verify their HSA distributions were used to pay for "qualified medical expenses" in the event of an IRS tax audit. Participants may obtain additional information regarding "qualified medical expenses" on the IRS website at ***www.irs.gov***, or by obtaining a printed copy of IRS Publication 502 (available from any regional IRS office) or by consulting their tax advisor.

Medical Care Expenses eligible for reimbursement under the Health FSA component shall include expenses for medicines or drugs incurred after December 31, 2010 *only* if the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item

is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied. Neither CHS nor its Third Party Administrator is liable for misused HSA funds.

Rollover of Unused Funds
If an unused balance remains in the HSA at the end of the Benefit Year, this amount will roll over to the following year.

If Participation in the Plan terminates, and the Participant properly elects COBRA continuation of coverage under the Plan, the Participant may use HSA funds to pay COBRA premiums while COBRA coverage is in effect. The Participant may also continue to use the funds to pay for other out-of-pocket costs while COBRA coverage is in effect.

If Participation in the Plan terminates, and the Participant chooses to transfer funds to a separate HSA trustee or custodian, the Participant must do so within sixty (60) days from the date the remaining HSA funds are distributed to the Participant or such funds will be subject to taxation.

Network Provider Plan
This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, he or she will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

Under the following circumstances, the Network payment will be made for certain Non-Network services:
- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network service area.
- If a Plan Participant is out of the Network service area and has a Medical Emergency requiring immediate care.
- If a Plan Participant receives the services of a Non-Network Provider in a Network facility, when the Plan Participant is not given the opportunity to specify or request the services of a Network Provider.
- If a Plan Participant receives Non-Network services and the provider has accepted a negotiated discount arranged either through MedCost or through a third party contracted by MedCost and/or MedCost Benefit Services.
- If, in the case of an acquisition, a Plan Participant is established in a treatment program with a Non-Network Physician. i.e., expectant mother is in her 3rd trimester, a Plan Participant receiving chemotherapy or radiation therapy, etc. (At the end of the current treatment cycle the Plan Participant should transfer his / her care to a Network Provider in order to receive Network benefits.)

Transition of Care
To ensure quality and continuity of care, if a Plan Participant's provider is not, or ceases to be, a Network Provider for reasons other than quality-related reasons, fraud, or failure to adhere to Network Provider policies and procedures, or a provider ceases to be a Network Provider due to a change in the network utilized by the Plan, coverage may continue for a period of 90 days for treatment in progress for a Plan Participant who is:
- in her second or third trimester of Pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or
- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Plan Participant's health; or
- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact mbsmedreview@medcost.com to request continuation of care with a Non-Network Provider as outlined above. Your written request must be received by MedCost Benefit Services within 60 days of the provider's termination date, or the date the provider is no longer accessible as a Network Provider. If your request is approved, Covered Medical Expenses incurred in connection with care provided will be subject to the same Copays, deductibles, coinsurance and limitations as when given by a Network Provider.

Deductibles / Copays
A deductible is an amount of money that is paid once a Benefit Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges that are subject to the deductible. Each January 1st, a new deductible amount is required.

A copay is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copays on some services and other services will not have any copays.

A combination of the Network and Non-Network deductible amounts will never exceed the Non-Network deductible amount.

Family Unit Limit
The Family Plan requires the entire Family Deductible to be satisfied before benefits are paid to any family members. This provision is called a "Non-Embedded Deductible" provision.

Deductible for a Common Accident
This provision applies when two or more Plan Participants in a Family Unit are injured in the same Accident. These persons need not meet separate deductibles for treatment of injuries incurred in this Accident; instead, only one deductible for the Benefit Year in which the Accident occurred will be required for them as a unit for expenses arising from the Accident.

Out-of-Pocket Maximums
A combination of the Network and Non-Network Out-of-Pocket amounts will never exceed the Non-Network out-of-pocket amount. No more than the amount(s) stated in the Schedule of benefits needs to be paid for allowable expenses during a Benefit Year. This amount caps the Plan Participant's coinsurance percentage (for example, 20%). For the rest of that year the Plan will pay 100% of certain allowable expenses exceeding the outlined amount. The Out-of-Pocket Maximum includes Copays, Coinsurance, and Deductibles, including On-Site Care and CHS Virtual Visit cost sharing, and excludes non-covered services, premiums, and any applicable penalties.

Covered Medical Expense
The term Covered Medical Expense means an expense incurred for Covered Charges, but only if the expense is incurred while you and / or your Dependent(s) are covered by this Plan, and only to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary care and treatment of an Injury or Illness.

Covered Medical Expense includes expenses filed in accordance with coding guidelines as defined by the current Uniform Billing Code, Centers for Medicare and Medicaid, ICD-9 (or its successors), and CPT-4. This includes coding according to the American Medical Association's (AMA's) guidelines that state the code(s) reported / billed "accurately identifies the service performed." The term Covered Medical Expense also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-9 (or its successors), CPT-4, and HCPCS codes with their appropriate modifiers for adjudication. Inclusion or exclusion of a procedure in, or from, one of the aforementioned sets of coding guidelines does not imply any coverage or entitlement to reimbursement.

Covered Medical Expense includes professional fees incurred when a professional service has specifically been provided to a Covered Person. A claim filed for a professional fee for a computer generated report is not a Covered Medical Expense.

The term Covered Medical Expense does not include charges billed according to inappropriate billing practices, including, but not limited to, billing for undocumented services, billing for services not rendered, unbundling, up-coding or balance billing. Such services should not be billed to the patient. Charges that are not coded in compliance with industry standards will not be deemed Covered Medical Expenses.

All charges are subject to Usual, Customary and Reasonable (UCR) determination. To determine UCR, the Claims Administrator shall consider the following factors:

- the provider's "Usual" charges comprised of the fees that an individual provider most frequently charges for a specific type of treatment or service; and
- the "Customary" charges, based on one or more of the following:
  - statistically credible health care services data (updated no less than quarterly); or
  - a Preferred Provider (PPO) fee schedule; or
  - Medicare-based reimbursement; and

- the “Reasonable” charges, based on consideration of:
  - charges based on a negotiated discount arrangement with the provider at issue for the charges in question; or:
  - for Non-Network charges, each of the following:
    - the complexity or severity of the treatment or service at issue; and
    - the level of skill and experience involved in delivery of the treatment or service; and
    - the value of the treatment or service compared to other treatments or services.

Charges that are not coded in compliance with industry standards are presumed to be unreasonable.

Charges will be considered in excess of UCR if they exceed any of these three factors (Usual, Customary and Reasonable). Charges in excess of UCR will not be considered Covered Medical Expenses. When charges are in excess of UCR, you may incur costs associated with charges that exceed Usual, Customary and Reasonable charges.

Balance Billing
In the event a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan’s position that the Plan Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Non-Network providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan’s position that the Plan Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has not control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Plan Participant is responsible for any applicable payment of coinsurance, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Medical Record Review
The Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a Clean Claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual, Customary, and Reasonable and/or Medically Necessary, if any, and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of Usual, Customary, and Reasonable amounts or other applicable provisions, as outlined in this SPD.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual, Customary, and Reasonable charge, in accordance with the terms of this SPD.

MEDICAL BENEFIT EXCLUSIONS

Charges for the following ***are not covered***:

Acupuncture or acupressure.

Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences; consultations. This exclusion does not apply to the Telemedicine benefit.

Ambulance Services. Ambulance services for non-emergency travel, including but not limited to, home to routine Outpatient medical treatment, Physician visits, physical therapy or chemotherapy, or travel that is not Medically Necessary.

Appointments. Charges for broken or missed appointments.

Blood donation. The Plan will not cover extra charges above the usual processing fee for procurement, storage or administration of blood that you or another person has donated for your use at an unspecified time.

Purchase of **breastfeeding equipment** from a retail store.

Chelation agents, except as Medically Necessary for the treatment of heavy metal poisoning.

Chiropractor. The following is not within a chiropractor's scope of practice and are excluded by the Plan:

- administering or prescribing medicine or drugs,
- the practice of osteopathy,
- diagnostic services, and
- surgery.

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered (except for emergency services in the case of an emergency).

Cosmetic surgery. Cosmetic surgery (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons, unless specifically covered by the Plan. (See Additional Benefits, Reconstructive Surgery.)

Custodial care. Care is considered custodial when it is primarily for personal need and could be provided by persons without professional skills or training. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medications. This Exclusion does not apply to a formal Hospice care program.

The Plan will not pay for Hospital care, nursing home or Skilled Nursing facility care, home care, or a school or other institution for behavior and/or developmental modification or care, or any other service that is custodial in nature.

Dependents. The Plan does not allow duplicate coverage of the same Dependents by married Employees.

Dental care. The Plan does not pay for the treatment of cavities, extractions, care of gums or bones supporting the teeth, orthodontia (including braces), bridges, dentures, dental root implants, root canals, false teeth or any dental services you may receive, except as specifically provided under *Covered Medical Expenses*.

Educational or vocational testing. Services for educational or vocational testing or training. This Exclusion does not apply to diabetic self-management programs for training for the use of diabetic supplies. *See also Learning Disorders/Testing.*

Educational or informational sessions for relatives of a patient receiving Mental Health or Substance Abuse treatment.

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is not a Covered Medical Expense.

Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental, Investigational or not Medically Necessary. Experimental, Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently, or at the time the charges were incurred, recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed.

This Exclusion may not apply to *Qualified Clinical Trial* services (see *Defined Terms*).

This Exclusion may not apply when a patient is receiving treatment that follows published protocol of a Qualified Clinical Trial and has satisfied the patient selection criteria, although the patient is not enrolled in the Qualified Clinical Trial. To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis.*

This Exclusion may not apply when a patient has been diagnosed with cancer for which there is not an established treatment protocol (Standard of Care). To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis. *

**For the purposes of determining if the "Experimental or not Medically Necessary" exclusion shall not apply due to the clinical evidence providing a reasonable expectation that the treatment will improve the patient's medical condition and prognosis, such reasonable expectation shall be determined solely by the Plan. The Plan reserves the right to utilize resources qualified to assist in such determinations as warranted.*

This exclusion may not apply to a drug which has been approved by the Federal Food and Drug Administration (FDA) for a specific medical condition, but which is sought to be provided for another medical condition. This is referred to as "off-label use". To be considered a covered expense by the Plan, off-label drugs being prescribed must have been:

1. Approved by the FDA for commercial distribution, and
2. Supported in reputable medical compendia* as effective and accepted treatment for the off-label condition.

**Reputable Medical Compendia includes, but is not limited to:*

Accc-cancer.org	Cancer.gov
Chemoregimen.org	Compendia
FDA.gov	Medscape.com
Medlineplus.gov	NCCN.org
NIH.gov	U.S. Pharmacopoeia

Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, (except as noted in *Pediatric Preventive Services* under Routine Wellness /Preventive Services), including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Foot care. Charges resulting from weak, unstable or flat feet; bunions; routine foot care including corn and callus treatment or removal; or nail trimming, unless necessary for diabetic foot care. This exclusion does not apply to surgery for the above listed conditions.

Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.

Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Genetic testing and counseling, except as noted in the *Schedule of Benefits* section of this document. Genetic testing for the purposes of determining the paternity of a child or the sex of a child is not covered.

Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

Growth hormones.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. This Exclusion does not apply to wigs purchased following cancer therapy. See *Schedule of Benefits*.

Hypnosis except when performed for control of acute or chronic pain at the Southeastern Pain Center.

Illegal Acts. Charges for services rendered as a result of an injury or illness which was caused by one of the following:

- The use of illegal narcotics or non-prescribed controlled substances (unless administered on the advice of a physician); or
- Being illegally intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place), while operating a motorized vehicle; or
- Engaging in a riot or public disturbance, aggravated assault, illegal occupation, or felony; or
- A Serious Illegal Act. A "Serious Illegal Act" is any act or series of acts for which a sentence to a term of imprisonment in excess of one year could be imposed (regardless of the individual's own criminal history) if the act were prosecuted as a criminal offense in the state where the act took place.

In each instance, it is not necessary that criminal charges be filed or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required. This exclusion does not apply to the victims of such acts. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a covered medical condition (including both physical and mental health).

Immunizations and/or Vaccines needed for travel.

Infertility. The Plan will not cover any costs for Infertility diagnosis or treatment if the covered Employee or covered Spouse has had a prior sterilization procedure or if infertility or reduced infertility is the result of a normal physiological change such as menopause. Also the Plan does not cover donor eggs or sperm, or charges incurred by a surrogate mother (unless she is a Plan Participant). Also, the Plan will not pay for charges incurred by a surrogate mother, including those incurred by a Plan Participant who is a surrogate mother, or in connection with a Pregnancy or attempted Pregnancy involving a surrogate mother.

Injectables. The Plan will not reimburse charges for the administration of injectable insulin and any other injectable drug that can be self-administered, unless medical supervision is required.

Inpatient confinements primarily intended as a change of environment.

Learning Disorders/Testing. Services, treatment and diagnostic testing related to learning disorders unless it is medical treatment for a diagnosed medical condition or disorder, such as auditory processing, severe language delays and/or severe phonological disorders which the covered Plan participant will not outgrow; and not only for behaviors associated with that diagnosis. This exclusion does not apply to pediatric preventive services when billed appropriately.

Mandated or Court-Order Care. The Plan will not pay for any medical, psychological or psychiatric care that is the result of a court order or mandated by a third party (such as, but not limited to your Employer, licensing board, recreation council or school), unless it is Medically or psychologically Necessary, or court-ordered pursuant to a Qualified Medical Child Support Order.

Marital or pre-marital counseling.

Massage therapy.

Never Events. Treatment or services for unintended injury or illness resulting from an adverse consequence of care that could reasonably have been prevented, including but not limited to: foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc. For more information see ***http://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage .***

No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Illness. Further, charges will not be paid for services, supplies or treatment not commonly and customarily recognized throughout the Physician's profession, or by the American Medical Association (AMA) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the AMA as having no medical value.

Non-Emergency Hospital Admissions. Any admission and related inpatient Hospital charges incurred on a Friday, Saturday, or Sunday unless the admission is necessary due to an emergency or if surgery is performed within 24 hours of the admission, unless the admission is pre-certified for medical necessity.

Non-Hospital institutions. The Plan will not pay for care or supplies in convalescent homes, facilities providing primarily custodial or rest care, or similar institutions. The Plan will not pay for care or supplies in health resorts, spas, sanitariums, tuberculosis Hospitals or infirmaries at camp.

Not Specified as Covered. Non-Traditional Medical Services, treatments and supplies which are not specified as covered under this Plan. *See Defined Terms.*

Occupational. No benefits will be provided for losses which result from an Illness or Injury:

- that arises out of or in the course of employment (including self-employment) with any employer who is eligible to obtain coverage under Workers' Compensation, or occupational disease law;
- for which the Plan Participant is eligible for benefits under any Workers' Compensation law or occupational disease law; or
- for which the Plan Participant is paid a Workers' Compensation benefit or occupational disease law benefit.

Personal Comfort Items. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in conjunction with custodial care, educational or training or expenses actually incurred by other persons except as specifically addressed elsewhere in this document. Personal comfort items include, but are not limited to: air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first aid supplies and non-hospital adjustable beds.

Plan design excludes. Charges excluded by the Plan design as described in this document.

Prescription and Non-Prescription drugs. The Plan will not pay for prescription or non-prescription drugs dispensed in the Physician's office, or non-prescription drugs purchased at a pharmacy.

Prophylactic mastectomy and hysterectomy surgeries. Prophylactic mastectomy and hysterectomy surgeries other than those specifically covered under *Additional Services, Reconstructive Surgery* may be excluded and are subject to medical necessity and require review through medical consulting for coverage determination.

Provider Error. Care, supplies, treatment, and/or services that are required as a result of unreasonable provider error. Providers are independent contractors, and they are solely responsible for injuries and damages to Plan Participants resulting from misconduct or negligence.

Psychoanalysis.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

Residential Treatment. Residential treatment for Mental Health and Substance Use Disorders is not covered for the following:

- The use of foster homes or halfway houses.
- For wilderness center training.
- For therapeutic boarding schools.
- For custodial care, situation or environmental change.

Room and Board for Partial Hospitalization. Charges billed for Room and Board in connection with any Partial Hospitalization services are excluded.

Sclerotherapy. The Plan will not cover cosmetic sclerotherapy (the injection of sclerosing solutions) for the treatment of varicose veins unless medically documented in advance of this treatment.

Self-Care. The Plan will not pay for a self-care unit, apartment or similar facility operated by or connected with a Hospital.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sex Change / Sexual Dysfunctions. Unless Medically Necessary, charges for services due to sexual dysfunctions, sex transformation, non-congenital transsexualism, gender dysphoria or sexual reassignment or sex change are excluded. This Exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy for problems related to sexual dysfunction or sex change.

Sexual offenders. The Plan will not pay for the care, services or treatment for sexual offenders.

Special Education. The Plan does not pay for any form of special education such as music therapy, remedial reading, recreational or activity therapy, or equipment or supplies used similarly.

Subrogation. Claims directly related to or arising out of an Injury or Illness for which the Plan Participant has, or may have, any claim or right to recovery, when the completed and signed acknowledgement form (as described in the Reimbursement and or Subrogation section) is not delivered to the Claims Administrator within 12 months of the date that such form is first sent by the Claims Administrator to the Plan Participant.

Surgical sterilization reversal.

Surrogacy. Charges incurred by a surrogate mother, including those incurred by a Plan Participant who is a surrogate mother, or in connection with a Pregnancy or attempted Pregnancy involving a surrogate mother.

Temporary Employees are not eligible for coverage under this Plan.

Termination of Pregnancy, elective or voluntary, after 16 weeks of pregnancy. Exceptions may be permitted if severe congenital anomalies are discovered later than 16 weeks.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges, and as stated as covered under the Transplant Services benefit, or for travel that is not Medically Necessary.

War. Any loss that is due to a declared or undeclared act of war.

Workers' Compensation. The Plan will not pay for any care or supplies for any Injury, condition or disease, if you are eligible to receive payment under a Workers' Compensation Law or similar law.

HEALTH MANAGEMENT SERVICES
MedCost Health Management
(800) 795-1023

The patient or family member must call (800) 795-1023 to receive certification of certain Health Management Services. This call must be made at least 48 hours in advance of services being rendered or within 72 hours after an emergency.

>>> Precertification is not a guarantee of coverage or payment. <<<

MedCost Health Management is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under this Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. The Health Management platform is a comprehensive and integrated selection of medical management programs designed for patient-centered health management.

The program components include:
- Utilization Review:
  - Precertification;
  - Concurrent Review;
  - Discharge Planning;
- Personal Care Management;
- Catastrophic Case Management;
- SmartStarts;
- Diabetic Care Management;
- Employee Assistance Program (EAP);
- Wellness Program; and
- On-Site Care

UTILIZATION REVIEW
Utilization review is a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

- Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
  - Hospital admissions;
  - transplant services;
  - Hospital Observation Unit stays of more than 48 hours;
  - dialysis services; and
  - Mental Health and Substance Use Disorders Services; (*See Appendix A for precertification through CBHA*).
- Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

Maternity Note: The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

In order to maximize Plan reimbursements, please read the following provisions carefully.

PRECERTIFICATION

Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance. The utilization review program is set in motion by a telephone call from the Plan Participant. Contact the utilization review administrator at the telephone number on your ID card at least 48 hours before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name and group number of the Employer
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The name and telephone number of the attending Physician
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 72 hours of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services appropriate for care

CONCURRENT REVIEW

After admission to the Medical Care facility, the utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services, and coordinate with the attending Physician, Medical Care Facilities and Plan Participant.

DISCHARGE PLANNING

If the attending Physician feels that it is Medically Necessary for a Plan Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days. Please remember that precertification does not guarantee coverage or payment. Contact MedCost Benefit Services Customer Service at (800) 795-1023 to verify your eligibility and benefits.

PERSONAL CARE MANAGEMENT

Personal Care Management (PCM) proactively identifies and manages individuals with health issues that, if addressed early, may not develop into more serious conditions. Personal Care Management provides one-on-one mentoring and monitoring for those who have previously fallen through the cracks because their conditions were not serious enough to require traditional case management or disease management. Experienced health coach nurses encourage positive health changes through education, mentoring and coaching, regular monitoring, and proactive and timely interventions.

Potential participants are identified through claims and pharmacy data, as well as internal referrals. Participation in PCM is voluntary. If you are contacted by a MedCost nurse mentor we hope you will choose to take advantage of this program to help you achieve a healthier lifestyle.

CATASTROPHIC CASE MANAGEMENT

When a catastrophic condition such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term care. After the person’s condition is diagnosed, he or she might need extensive services, or might be able to be moved into another type of care setting – even to his or her home.

Case Management is utilization review for services and supplies needed by a patient with a serious, complicated, or protracted health condition. It may include discharge planning, which is done to coordinate and manage the care

a patient receives after discharge from a Hospital or Skilled Nursing Facility. The goal of Case Management is to identify safe, effective treatment alternatives in lieu of more costly ones.

Sometimes, treatment that may not otherwise be covered by the Plan may be recommended as 'alternative treatment'. The Plan will provide benefits for alternative treatment that is approved and agreed upon by the Plan, the Covered Person and the Covered Person's doctor, if it is determined that such alternative treatment is medically necessary and cost effective. An example of alternative treatment is Home Health Care or Skilled Nursing beyond Plan limits. Providing benefits for alternative treatment in one situation does not require the Plan to provide similar benefits in another. This provision is not a waiver of the Plan's right to administer the Plan in strict accordance with its terms.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient
- contacting the family to offer assistance and support
- monitoring Hospital, Rehabilitation or Skilled Nursing facility confinements;
- determining alternative care options; and,
- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SMARTSTARTS (800) 433-9178

If you or your Spouse is pregnant, take advantage of the helpful information available to growing families through the MedCost SmartStarts Maternity Management Program. SmartStarts is a voluntary Employee wellness program, focused on educating expectant mothers and mentoring them through each trimester of Pregnancy. SmartStarts has a great educational website that is available to you as a free benefit under your health care coverage. Throughout their Pregnancy, program participants may also call a toll-free number that gives them instant access to a prenatal nurse whenever they have a question.

The SmartStarts website is available anytime, day or night and offers the following features:

- Educational information by trimester
- Ability to communicate with nurse mentors via secure email
- Links to freebies and coupons
- Tip of the Month
- SmartStarts Program FAQs, statistics and success stories
- Special section just for Dad
- Old wives tales
- Top 10 baby names
- Fun stuff for baby's brother or sister
- Take an online risk assessment

To take advantage of this excellent resource, simply visit ***www.medcost.com*** and click on the SmartStarts icon at the bottom of your page. Although participation is voluntary*, we hope you or your spouse will maximize this free benefit early in the pregnancy to ensure the healthiest outcome for both mother and baby. *Your Employer has established an incentive for participation in SmartStarts. If you enroll within twenty (20) weeks, a SmartStarts incentive of $300 is deposited in the Health Savings Account (HSA) upon completion of the program.

DIABETIC CARE MANAGEMENT

The Plan will provide coverage for Medically Necessary diabetes outpatient self-management training and educational services. Refer to *Nutritional Counseling* for further details. Your Employer has established an incentive for participation in Diabetic Care Management.

EMPLOYEE ASSISTANCE PROGRAM (EAP) (800) 384-1097

Available through Carolinas HealthCare System, this program is designed to help you and members of your family with all types of issues – marital conflict, financial problems, job stress, emotional problems, alcohol and drug problems, legal issues and difficulties with children.

There is no charge to you when you visit with an EAP counselor. The counselor will help clarify your concerns and offer treatment options. If further counseling is required, you will be referred to area treatment professionals whose services can often be billed to your health plan. Your decision to use EAP is voluntary and confidential. The counselors must follow strict legal guidelines regarding disclosure or program participation.

For more information, call the EAP office of Carolinas HealthCare System at 800-384-1097. Coverage under CHS On-Site Care (below) includes the Employee Assistance program (EAP) as defined above.

LiveWELL (704) 355-8136 or ***http://livewell.carolinashealthcare.org***

LiveWELL is the CHS employee wellness program that provides a wide range of services including nutrition and weight loss resources**,** fitness classes, smoking cessation and more. In addition, teammates who are enrolled in the Carolinas HealthCare System LiveWELL Health Plan can take advantage of the LiveWELL Incentive Program. While services are voluntary, you can earn Health Savings Account contributions by completing certain wellness criteria throughout the year. For more details on the program or to review timelines and criteria requirements, please visit ***livewell.carolinashealthcare.org***.

EMPLOYEES ONLY ON-SITE CARE

CHS On-Site Care is available to all Employees of Carolinas HealthCare System, including those enrolled in the Carolinas Healthcare System LiveWELL Health Plan **as well as those who are not enrolled in the Plan**. CHS On-Site Care is for CHS employees only. Non-CHS employee dependents, including spouses, children, etc., are not eligible for CHS On-Site Care.

CHS On-Site Care is available to treat illnesses with symptoms that are expected to last for a short duration with treatment including cold, cough, bronchitis and flu; ear, sinus, and upper respiratory infections; seasonal allergies; or minor injuries such as splinters, sprains or cuts, and occupational injuries/illnesses. There are no fees for visits as a result of occupational injuries / illnesses.

A nurse practitioner, also commonly known as a mid-level provider, will provide care at each location. The nurse practitioner is supervised by a licensed physician in the State of North Carolina and, under the rules, can practice independently. The nurse practitioner can diagnose and treat injuries and illnesses and write certain levels of prescriptions if needed.

Employees are eligible to visit the clinic even if they are covered by the Carolinas HealthCare System LiveWELL Health Plan. For visits other than for occupational injuries / illnesses:

Employees enrolled in the Plan will pay a fee in the range of $49-$149 depending on the level of service until the annual deductible is met, but may use their Health Savings Account to pay for services. After the deductible is met Employees enrolled in the Plan will pay a fee of $10 that applies toward the Out-of-Pocket Maximum.

Please note: CHS On-Site Care does not provide any Coordination of Benefits with any plan of health care coverage.

Please note: COBRA coverage will be available to any Employee upon termination from the Employer as provided under the COBRA provisions. However, COBRA coverage will not be available to the spouse or dependent children of any Employee who was not properly enrolled and covered by the Carolinas Healthcare System LiveWELL Health Plan regardless of whether the Employee utilized the services of the On-Site Care program.

*C*overage under the On-Site Care program includes CHS On-Site Care and the Employee Assistance program (EAP) as defined above.

CLAIMS PROCEDURES AND APPEALS

CLAIM DETERMINATIONS MADE IN ACCORDANCE WITH PLAN DOCUMENTS

The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Plan Documents and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated Covered Persons.

CLAIM DEFINED

A "Claim" represents a Clean Claim that is any request made by a Covered Person or a Covered Person's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing Claims. A request for benefits includes a request for coverage determination, pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Refer to Defined Terms, Clean Claim.

Requests for eligibility determinations are not Claims for benefits. However, when a Claim is denied because the Covered Person is not eligible for benefits under the terms of the Plan, the Covered Person has the right to appeal that determination in accordance with the Plan's Claims procedures.

CLAIM FILING

Network providers will file medical claims to MedCost Benefit Services for you. If you incur a claim from a Non-Network provider, or a provider that does not file the claim, you can submit the claim by following these steps:

- Complete the Employee's portion of a claim form.
- Have the Physician or Dentist complete the Provider's portion of the claim form.
- Attach all related bills to the claim form. All bills MUST show:
  - Plan name (employer's name) and group number
  - Employee's name
  - Patient's name
  - Provider's name, address & phone number and tax identification number
  - Date(s) of services, diagnosis, type of service rendered including diagnosis or procedure code(s)
  - Charges

Send the completed claim form to the Claims Administrator at:
MedCost Benefit Services
PO Box 25987
EDI 56205
Winston-Salem, NC 27114-5987
Or by email to ***mbswebmail@medcost.com.***

Claims should be submitted to MedCost Benefit Services as soon as possible after the date of service, preferably within 90 days, but not more than 18 months. When a Plan Participant's coverage terminates for any reason, claims need to be submitted to MedCost Benefit Services within 90 days of termination of coverage. Refer to Defined Terms, Clean Claim.

LIMITATION OF LIABILITY

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "Claim Filing" above, except in the case of legal incapacity of the Covered Person.

URGENT CARE CLAIM

The term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next sentence, whether a claim is an urgent care claim is to be determined by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Covered Person's medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

For urgent care claims, the Claims Administrator will notify the Covered Person of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim at the initial benefit

determination level. Notice of a benefit grant or denial may be provided orally, so long as a written or electronic notice of benefit grants or denials is sent to the Covered Person not later than 3 calendar days after the oral notification.

PRE-SERVICE CLAIM
A pre-service claim is any claim for a medical benefit under this Plan that requires approval, in whole or in part, in advance of obtaining medical care. These are, for example, Claims that are subject to predetermination of benefits or pre-certification.

For pre-service claims, generally, the Claims Administrator must notify the Covered Person of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

POST-SERVICE CLAIM
A post-service claim is a claim for a Plan benefit that is not a claim involving Urgent Care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

For post-service claims, generally, the Claims Administrator will notify the Covered Person of any adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of post-service claims.

INCOMPLETE CLAIMS NOTICE DISCLOSURE
The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing.

The Claims Administrator must notify the Covered Person or Covered Person's representative of failure to follow proper claims filing procedures.

- With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim.
- With respect to pre-service claims, notice of incomplete claims will be provided within 5 days of receipt of the claim.

Notification by the Claims Administrator may be oral, unless written notification is requested by the Covered Person or Covered Person's authorized representative.

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

The Claims Administrator shall provide a Covered person with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Covered Person, the following:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions upon which the determination is based;
- A description of any additional material or information necessary for the Covered Person to perfect the claim and any explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Person's right to bring a civil action under following an adverse benefit determination on review;
- If the Plan utilizes a specific internal rule, guideline, protocol, or other similar criterion in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or similar criterion will be provided free of charge to the Covered Person upon request;
- If the determination is based on not satisfying the criteria for clinical eligibility for coverage; experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Covered Person's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- In the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

INTERNAL APPEAL OF DENIED CLAIM AND REVIEW PROCEDURE

A Covered Person will be notified in writing by the Claims Administrator if a claim, or any part of a claim, is denied. If a Covered person does not agree with the reason for the denial, the Covered Person may file a written appeal within 180 days after the receipt of the original claim determination.

An adverse benefit determination is eligible for internal appeal and review if it includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

The request for review must contain the Covered Person's name and identification number and the basis for the disagreement along with any information, questions, or comments the Covered Person thinks are appropriate, and should be sent to the office of the Claims Administrator. Copies of any relevant documentation (such as letters, claims, medical records, physician's statements, etc.) should be provided to the Claims Administrator.

The Covered Person's claim appeal will be reviewed and the decision made by someone who was not involved in the initial determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the Covered Person without regard to whether such information was previously submitted or considered in the initial determination.

In addition, in deciding an appeal of any determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or is determined not to satisfy the criteria for clinical eligibility for coverage or is not appropriate, the appropriate reviewer shall consult with a health care professional, who was neither the person who was consulted in connection with the initial benefit determination, nor the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a pre-service claim within 30 days from receipt of the appeal.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a post-service claim within 60 days from receipt of the appeal.

EXPEDITED INTERNAL APPEAL
In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the Covered Person; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Person by telephone, facsimile, or other available similarly expeditious method.

The Claims Administrator will notify the Covered Person, by telephone, of the determination of an expedited appeal within 24 hours from receipt of the expedited appeal. A written notification will be sent to the Covered Person within 3 days after notification by telephone.

EXTERNAL REVIEW
When a Covered Person disagrees with an internal appeal decision, the Covered Person has 4 months following receipt of the appeal notice in which to request an external review. The external review will be conducted by an Independent Review Organization (IRO) that is accredited by URAC (Utilization Review Accreditation Committee).

Within 5 business days of receipt of a request for external review, the Claims Administrator will complete a preliminary review and issue a notification in writing to the Covered Person that the request is complete and eligible for external review.

If the request is not complete, the notification will include information or materials needed to make the request complete. The Covered Person is permitted a 4-month time period to submit the information or materials needed.

When all information has been received, the Claims Administrator will assign the request to an IRO, and will forward all information to the IRO.

The IRO will notify the Covered Person in writing of the request's eligibility and acceptance for external review. The Covered Person is permitted 10 business days in which to submit additional information that the IRO must consider in conducting the external review.

The IRO will forward to the Claims Administrator any additional information provided by the Covered Person and permit the Claims Administrator to reconsider and/or reverse the adverse determination.

If the Claims Administrator reverses the adverse determination, the external review will be terminated. If the Claims Administrator upholds its adverse determination, the external review process continues.

The IRO will provide written notice of its final external review decision within 45 days after the IRO received the request for external review. The notice will be provided to the Covered Person and to the Claims Administrator and will included detailed information that includes the reason(s) and rationale for the decision.

The determination by the IRO is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Covered Person.

EXPEDITED EXTERNAL REVIEW
An expedited external review may be requested for an adverse determination that involves a medical condition of the Covered Person for which the regulatory time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function. In other words, an expedited external review may be requested to run concurrently with an expedited internal appeal.

Upon determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO and forward all documentation to the IRO electronically, or via facsimile.

The IRO will review the information and provide a final determination within 72 hours after receipt of the information.

The determination may be communicated to the Covered Person orally, but will also be provided in writing to the Covered Person and the Claims Administrator within 48 hours after the determination is made. Claims paid as a result of an IRO determination may be considered eligible claims under this Plan.

AUTHORIZED REPRESENTATIVES
A Covered Person's authorized representative, including a health care provider, is not precluded from acting on behalf of the Covered Person in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a Covered Person's medical condition as the Covered Person's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether a person has been authorized to act on behalf of a Covered Person.

PAYMENT OF BENEFITS
All benefits under the Plan are payable to the covered employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of incapacity of a covered employee and in the absence of written evidence to the Plan of the qualification of a guardian (or person acting under durable power of attorney) for the covered employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee. In the event of death, the personal representative of the estate will act on behalf of the covered employee.

Benefits for expenses covered under the Plan may be assigned by a covered employee to the individual or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received and accepted by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will pay benefits in accordance with any assignment of rights under a state Medicaid law.

Assignment of Benefits
Assignment by a Plan Participant to the provider of the Plan Participant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the provider accepts said Assignment of Benefit as consideration in full for services rendered. If benefits are paid, however, directly to the Plan Participant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Plan Participant's responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid, and the Plan Participant shall retain final authority to revoke such Assignment of Benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Plan Participant, has been received.

No Plan Participant shall at any time, either during the time in which he or she is a Plan Participant in the Plan, or following his or her termination as a Plan Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or it fiduciaries.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered 'assigned' to such provider and will be paid directly to such provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with the applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based on improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or Dependent on whose behalf such payment was made.

A Plan Participant, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest at the legal rate, not to exceed 8% per annum. If the Plan must bring an action against a Plan Participant, provider or other person or entity to enforce the provisions of this section, then that Plan Participant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Reimbursement and/or Subrogation provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his/her covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Plan Participant for any outstanding amount(s).

RECOVERY OF OVERPAYMENTS

If an overpayment is made under this Plan, the Claims Administrator reserves the right to determine and exercise one or all of the following options that it deems necessary to recover the overpayment to the Plan. The Claims Administrator may:

- request the overpayment from any Covered Person to whom such overpayment was made;
- request the overpayment from any provider to whom such overpayment was made; and/or
- deduct the overpayment of benefits from subsequent benefits payable to the Covered Person.

Each Covered Person is deemed, through participation in the Plan, to authorize recovery of overpayments as described above.

COORDINATION OF BENEFITS

When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan or the couple's covered children are covered by two or more plans, the plans will coordinate benefits when a claim is received.

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. The insurance companies and/or third party administrators involved work together to pay up to 100% of the Plan Participant's covered expenses. This Plan uses the Credit banking method: When a plan is secondary, it shall reduce its benefits so that the total benefits paid by all plans during a claim period are not more than 100 percent of the total allowable expenses. The secondary plan shall calculate its savings by the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period.

COB applies to health care coverage that provides medical, vision, dental or health benefits by means of:

- A group plan on an insured basis;
- Plans that cover people as a group, including self-funded plans;
- Plans that are arranged through an employer, trustee or union;
- A prepayment plan such as an HMO, POS or PPO;
- Government plans; except Medicaid; and
- Single or family subscribed plans issued under a group plan.

The term "benefit plan" does not include:

- Hospital indemnity type plans;
- Types of plans for students;
- Franchise policies purchased by an individual;
- Automobile policies;
- Homeowners policies; and
- Other individual or family insurance policies for which premiums are paid by the Plan Participant.

For a charge to be considered under COB it must be a Usual, Customary and Reasonable (UCR) Charge as defined in the section entitled Coverage of Medical Expenses, and at least part of it must be covered under this Plan. Note: COB does not apply to Prescription Drug benefits. If a Plan is secondary for medical benefits, the assumption is that the Plan will also be secondary for Prescription Drug benefits.

In order for COB to work, the Plan may release or obtain claim information from any insurance company, organization or person. Accepting benefits under this Plan for incurred medical and/or dental expenses automatically requires a Plan Participant to give this Plan the information it requests about other plans and their payment of covered expenses.

If the Plan Administrator determines that this Plan has paid in error, the Plan will:

- Recover the amount paid to the Plan Participant or another benefit plan when the benefits should have been paid by the other benefit plan; or
- Repay other plans for benefits the Plan should have paid.

Benefits are coordinated on a Benefit Year basis.

Rules for Benefits Plan Payment Order
When two or more plans provide benefits for the same charge, insurance companies and/or third party administrators will follow these rules.

1. Plans that do not have a coordination provision will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the allowed charge:
   a. The benefits of the plan that covers the person directly (that is, as an Employee, Member or Subscriber) ("Plan A") are determined before those of the plan that covers the person as a Dependent ("Plan B").

b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. Coverage provided an individual as a Retired Employee and as a Dependent of that individual's Spouse as an Active Employee will be determined under item 2.a. above. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

c. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
   i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
   ii. If both parents have the same birthday, the benefits of the benefit plan that has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

e. When a child's parents are divorced or legally separated, these rules will apply:
   i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
   ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
   iii. This rule will be in place of items above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
   iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
   v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

3. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowed charges when paying secondary.

4. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

5. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

6. When there is dual coverage through both COBRA and other group health coverage the rules for determining which plan is primary will be applied in the standard order as they are listed above; in other words, the first rule that describes the situation is the rule to follow.
   a. Non-dependent or dependent (2.a. above). A plan covering an individual as an employee, member, subscriber, or retiree, is primary and the plan that covers the person as a dependent is secondary.
   b. Active or inactive employee (2.c. above). A plan covering an individual as an active employee (neither laid-off nor retired) or as the employee's dependent is primary.
   c. Child covered under more than one plan (2.d. and 2.e. above). The second rule describes which parent's plan will be primary and which will be secondary in a variety of circumstances.
   d. Continuation coverage. A plan covering an individual as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage (pursuant to state or federal law) is secondary.

MEDICARE AS SECONDARY PAYER
The federal Medicare Secondary Payer (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account in determining whether these individuals are eligible to participate in the Plan, or in providing benefits under the Plan. If you or your covered Dependent is eligible for Medicare, the following MSP rules apply:

If your employer has 20 or more Employees, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; and your covered Spouse is age 65 or older, regardless of your age.

If Medicare is elected as primary coverage, the law does not permit the Company's medical plan to provide benefits supplementing Medicare. Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, ***you must terminate participation in the Company's medical plan*** and have Medicare as your only coverage. You should contact the Company if you wish to terminate your participation in the Plan and have Medicare provide your medical benefits. Otherwise, participation in the Company's medical plan will continue to provide your primary medical benefits, with Medicare providing supplemental coverage.

If your employer has 100 or more Employees, medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.

For all employers, medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

If this Plan is the primary payer under the above rules, it will provide the same medical benefits that it provides for other Plan Participants who are not entitled to Medicare benefits.

If Medicare is the primary payer for you or any of your covered Dependents, medical benefits will be paid in accordance with the *COORDINATION OF BENEFITS* provisions of the Plan.

MEDICAID
If you or any of your covered Dependents qualify for coverage under Medicaid:
- Your medical benefits under this Plan will be paid before any Medicaid benefits are paid;
- Eligibility and benefits under this Plan are not affected by Medicaid eligibility; and
- Benefits for a Plan Participant who is also covered by Medicaid are subject to the state's rights to subrogation and reimbursement, if Medicaid benefits have been paid first for covered medical charges.

Right to Receive and Release Necessary Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administration, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator, such information as requested and as may be necessary to implement this provision.

REIMBURSEMENT AND / OR SUBROGATION

A. If a Plan Participant receives any benefits arising out of an Injury or Illness (herein, referred to collectively as "Injury") for which the Plan Participant has or may have any claim or right to recovery:

- payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim of right to recovery;
- payment of benefits under this Plan shall be conditioned upon, and no payments under this Plan of benefits shall be made until, acknowledgment in a form specified by the Plan of the agreement of the Plan Participant, and his attorney, to the terms of this Section; and
- payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgment of the Plan's rights under this Section is hindered or breached.

B. The Plan Participant agrees:

- to refrain from doing anything to prejudice the Plan's rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
- to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement rights;
- that any such funds received will be held in constructive trust for the reimbursement of the Plan inasmuch as the Plan Participant is not the rightful recipient of such funds and should not be in possession of any funds until the Plan has been fully reimbursed;
- to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
- to assign to the Plan and its designees all rights against such agents and attorneys to enforce the direction to hold the funds in trust; and
- to reimburse the Plan in full before any amounts (including, but not limited to, attorney fees, expenses or costs), are deducted from such funds.

The Plan Participant shall be required to cooperate in the timely response to, and submission of, such acknowledgment form, requested related information and executed documents as may be required in order to facilitate benefit payment related to a subrogation claim. Failure to return the required completed and signed subrogation acknowledgment form and other requested documents to the Claims Administrator within 12 months from the date that such form (s) is (are) first sent by the Claims Administrator to the Plan Participant shall result in a loss of coverage for all claims directly related to or arising out of the Injury or Illness. The preceding sentence shall also apply to the obligations of Plan Participant's counsel under Paragraph E. below. *(Please see also Medical Benefit Exclusions under Subrogation.)*

C. Recoveries subject to the Plan's reimbursement claims shall include funds or rights acquired by the Plan Participant (1) from any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant's own insurance coverage); (2) any person, entity, corporation, plan, association, liability coverage or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or (3) worker's compensation award, settlement or agreement.

D. Without limiting the preceding paragraph C., this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the Injury which the Plan Participant claims an entitlement to benefits under this Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant's own insurance coverage).

E. If the Plan Participant retains an attorney, the attorney must sign the forms specified by the Plan Administrator acknowledging and agreeing to the terms of this Section as a condition of payment of any benefits. By so acknowledging, the attorney indicates agreement that the Plan expressly rejects application of the "make whole" doctrine, the "common fund" doctrine, and any equitable or legal remedies or defenses that would preclude the 100% reimbursement of the Plan out of first dollars recovered from any source, regardless of whether the Plan Participant will recover any funds from the source after reimbursement of the Plan and regardless of whether the attorney will be compensated or reimbursed for any fees, costs or expenses. The Plan will pay no costs or attorneys' fees, nor reduce its claims for reimbursement.

F. The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Plan Participant without regard to whether the Plan Participant is made whole. This paragraph is intended as an express and complete repudiation of the "make whole" doctrine, the "common fund" doctrine, or any equitable or legal remedy or defense to 100% reimbursement and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment.

G. If any action is taken by the Plan Participant, or his or her representatives to hinder, defeat or compromise the Plan's rights under this Section, the Plan Participant agrees by receipt of benefits under this Plan, that the Plan may deduct from present or future claims for payment under this Plan, or any other plan or program of benefits (e.g., disability, sick pay or paid leave) until the Plan has recouped full reimbursement of all expenditures relating to the Injuries as set forth in this Section.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA contains provisions giving certain former Employees, Spouses and Dependent children the right to temporary continuation of health coverage.

Beneficiary
A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event. A Qualified Beneficiary may be an Employee, the Employee's Spouse and Dependent children, and in certain cases, a Retired Employee, the Retired Employee's Spouse and Dependent children. COBRA continuation coverage is provided subject to your eligibility for coverage. See also Rescission of Coverage.

Qualifying Events
"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for **Employees** are:
- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **Spouses** are:
- Termination of the covered Employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered Employee
- Covered Employee becoming entitled to Medicare
- Divorce or legal separation of the covered Employee
- Death of the covered Employee

The types of qualifying events for **Dependent children** are the same as for the Spouse with one addition:
- Loss of "Dependent child" status under the plan rules

Periods of Coverage

Qualifying Events	Beneficiary	Coverage
-Termination -Reduced hours	-Employee -Spouse -Dependent child	-18 months
-Employee entitled to Medicare -Divorce or legal separation -Death of covered employee	-Spouse -Dependent child	-36 months
-Loss of "dependent child" status	-Dependent child	-36 months

Your Rights; Notices and Elections Procedures
COBRA outlines procedures for Employees and family members to elect continuation coverage and for Employers and plans to notify beneficiaries. The Qualifying Events contained in the law create rights and obligations for Employers, plan administrators and qualified beneficiaries.

Qualified Beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices
An initial general notice must be furnished to covered Employees, their Spouses and newly hired Employees informing them of their rights under COBRA and describing provisions of the law.

Specific Notices

Specific notice requirements are triggered for Employers, Qualified Beneficiaries and plan administrators when a Qualifying Event occurs. Employers must notify plan administrators within 30 days after an Employee's death, termination, reduced hours of employment, or entitlement to Medicare.

A Qualified Beneficiary must notify the Plan Administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a Qualifying Event, must automatically provide a notice to Employees and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a Qualifying Event has occurred.

Election

The election period is the time frame during which each Qualified Beneficiary may choose whether to continue health care coverage under an Employer's group health plan. Qualified Beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the Qualified Beneficiary.

A covered Employee or the covered Employee's Spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary. Each Qualified Beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a Qualified Beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Covered Benefits

Qualified Beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under plans maintained by the Employer. Assuming a Qualified Beneficiary had been covered by three separate health plans of his former Employer on the day preceding the Qualifying Event, that individual has the right to elect to continue coverage in any of the three health plans.
Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active Employees may apply to Qualified Beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

Duration of Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for Qualifying Events due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a Qualifying Event and can end when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.

- The Employer ceases to maintain any group health plan.
- Coverage is obtained with another Employer group health plan
- A beneficiary is entitled to Medicare benefits.

Special rules for disabled individuals may extend the maximum periods of coverage. If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the Qualified Beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to Qualified Beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Paying for COBRA Coverage
Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 % of the cost to the plan for similarly situated individuals who have not incurred a Qualifying Event. Premiums reflect the total cost of group health coverage, including both the portion paid by Employees and any portion paid by the Employer before the Qualifying Event, plus 2% for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The Plan must allow you to elect to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the Pan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1st and coverage for January could not be canceled if payment is made by January 31st.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the Pan. The Plan, however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

Claims Procedures
Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whoever is designated to operate the health plan (Employer, Plan Administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:
- provides for a special hearing, or
- the decision must be made by a group that meets only on a periodic basis.

Contact the Plan Administrator for more information on filing a claim for benefits. Complete plan rules are available from Employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Coordination with Other Benefits
The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an Employer to maintain coverage under any "group health plan" for an Employee on FMLA leave under the same conditions coverage would have

been provided if the Employee had continued working. Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a Qualifying Event under COBRA. A COBRA Qualifying Event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as when an Employee notifies an Employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Role of the Federal Government
Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements. If you need further information on your election or notification rights with a private sector plan, write to the nearest office of the Employee Benefits Security Administration or the U.S. Department of Labor, Employee Benefits Security Administration, Division of Technical Assistance and Inquiries, 200 Constitution Ave., N.W. (Room N-5619) Washington, D.C. 20210.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." Information about COBRA provisions concerning public sector employees is available from the:

U.S. Public Health Service Office of the Assistant Secretary for Health Grants Policy Branch (COBRA) 5600 Fishers Lane (Room 17A-45) Rockville, Maryland 20857

CONCLUSION
Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. COBRA creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your health benefits plan.

Be sure to periodically contact the Plan Administrator to find out about any changes in the type or level of benefits offered by the plan.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident is a non-occupational bodily Injury sustained independently of all other causes; that is sudden, direct and unforeseen, and is exact as to time and date.

Adult Woman means 18 years of age and over.

Adverse Benefit Determination means any of the following:
1. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Plan Participant's eligibility to participate in the Plan.
2. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
3. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Assignment of Benefits means an arrangement whereby the Plan Participant, at the discretion of the Plan Administrator, assigns their rights to seek and receive payment of eligible Plan benefits, less deductibles, Copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this SPD, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this SPD. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and deductibles, Copayments and the coinsurance percentage that is the responsibility of the Plan Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole beneficiary.

Benefit Year means the 12-month period in which covered medical expenses accrue and are counted toward the annual deductible and out-of-pocket limits, if applicable.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Carolina Behavioral Health Alliance is a network of mental health and substance use disorder professional counselors, psychiatrists, licensed clinical psychologists, licensed professional counselors, licensed psychological associates, licensed fee-based pastoral counselors, certified social workers and certified substance use disorder counselors. These providers are referred to as Network Providers. *See Appendix A.*

Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Clean Claim. A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim

does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Charges in accordance with the terms of this document.

Filing a Clean Claim: A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Charges as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means a fixed percentage of charges you must pay each time you receive a particular covered service.

Complications of Pregnancy. The Plan considers the following conditions as complications of pregnancy:

- miscarriage or missed abortion;
- eclampsia;
- ectopic pregnancy;
- nephrosis or acute nephritis;
- cardiac decompression;
- hyperemesis gravidarum;
- other pregnancy related conditions that are medically severe.

False labor; occasional spotting; morning sickness; prescribed rest or similar conditions not recognized as a complication of pregnancy are not covered by the Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan. *See section entitled Coverage of Medical Expenses*.

Covered Medical Expense(s). *See section entitled Coverage of Medical Expenses*.

Covered Person is an Employee, Spouse or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-administered.

Dependent means the covered Spouse and/or covered child(ren) of the Covered Employee.

Designated Transplant Provider means a Physician or health care facility that has met the strict medical criteria of MedCost Medical Management and/or the Plan's stop loss carrier, for the transplantation of human organs and/or tissues.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Medical Condition is defined as the sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could 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 or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Examples include, but are not limited to, heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, convulsions, serious falls, spinal injuries, shock or other severe, acute conditions that may require transport to the nearest hospital emergency room via ambulance or medical transport.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee means a person who is a regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Carolinas HealthCare System.

Enrollment Date is the first day of coverage if there is a Waiting Period, the first day of the Waiting Period.

Experimental, Investigational or not Medically Necessary. Experimental or Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently, or at the time the charges were incurred, recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed. *See Medical Benefit Exclusions*.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Foster Child means a child for whom a covered Employee has assumed a legal obligation.

A covered Foster Child is ***not*** a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Gender Identity Disorder (GID) is the formal diagnosis used by professionals to describe persons who experience significant gender dysphoria (discontent with their biological sex and/or birth gender).

Generic drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any generic pharmaceutical approved by the Food and Drug Administration when dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about:

- An Employee's genetic tests
- Genetic tests of an Employee's family members (up to and including fourth-degree relatives and a fetus or embryo)
- Any manifestation of a disease or disorder in a family member
- Participation of an Employee or family member in research that includes genetic testing, counseling, or education.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that:

- is operating in accordance with the law of the jurisdiction in which it is located, pertaining to institutions identified as Hospitals;
- is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnosis, treatment and care of Injured or sick persons by or under the supervision of a staff of Physicians or Surgeons;
- continuously provides 24-hour nursing services by graduate registered nurses (RNs);
- maintains facilities on the premises for major operative surgery;
- is not an institution established primarily for the Custodial Care of patients such as a rest home or nursing home but rather renders recognized medical services for the treatment of medical or psychiatric conditions.
- is a Hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA).

The definition of “Hospital” may also include:

- a facility operating legally as a psychiatric Hospital for Mental Health and licensed as such by the state in which the facility operates.
- a facility operating primarily for the treatment of Substance Use Disorders (alcohol and/or drugs) that maintains permanent and full-time facilities for bed care, has a Physician in regular attendance, continuously provides 24-hour day nursing service by a registered nurse, has a full-time psychiatrist or psychologist on the staff and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

A qualified provider of psychiatric rehabilitative treatment:

- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Psychiatric Rehabilitative Treatment Center under Defined Terms.

Note: A psychiatric Hospital for Mental Health or treatment of Substance Use Disorders is exempt from the requirement that it maintains facilities on its premises for major operative surgery.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means the medical inability of a male and female couple to conceive by natural means, or the inability to sustain a pregnancy to term.

Infertility Services means the medical treatment of a Plan Participant who is unable to conceive.

Injury means a condition caused by accidental means that results in damage to the Plan Participant’s body from an external force. Benefits are payable only for Injuries incurred while not engaged in work-related activities.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient (or Intensive Outpatient Program). An Intensive Outpatient Program (IOP) is a kind of treatment, service and support program used primarily to treat eating disorders, depression, self-harm and

chemical dependency that does not rely on detoxification, and is group-based and non-residential. A typical IOP consists of 3 hours of care 3 times per week, where the patient lives at home or another environment; however, the frequency and length of treatment sessions may vary.

A qualified **Institutional Review Board (IRB)** is one that meets all the federal requirements for the operation of an IRB as specified in the Code of Federal Regulations, and has not been disqualified to oversee clinical research by the NIH or FDA and has taken corrective action to rectify any noncompliance issue raised by the NIH or FDA within the past three years and has passed all subsequent NIH or FDA inspections.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed at least one of the following:

1. The Usual, Customary and Reasonable amount.
2. The allowable charge under the terms of the Plan.
3. The negotiated rate established in a contractual arrangement with a provider.
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual, Customary and Reasonable amount. The Plan has the discretionary authority to decide if a charge is Usual, Customary and Reasonable and for a Medically Necessary service. (Refer to Covered Medical Expenses.)

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

MedCost Benefit Services, LLC is the third party administrator contracted by the Plan to oversee the Plan and pay claims for the Employer.

MedCost is a Preferred Provider Organization (PPO). This is a network of medical care providers who agree to participate in a special cost containment program. Under this program, Plan Participants who use the services of a PPO (Network) provider receive greater levels of benefits than those who choose to use a Non-PPO (Non-Network) provider.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is recognized by the general psychiatric community.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Plan Participant.

Network Hospital, Physician or Provider means a Hospital, Physician or other provider that has an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

Non-Network Hospital, Physician or Provider means a Hospital, Physician or other provider that does not have an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

Non-Traditional Medical Service or Services means any practice or therapy that is perceived by its users to have the healing effects of medicine, but does not originate from evidence gathered using the scientific method, is not part of biomedicine, or is contradicted by scientific evidence or established science. Examples include, but are not limited to, homeopathy, naturopathy, and energy medicine.

Observation means services furnished by a Hospital on the Hospital's premises, including use of a bed and periodic monitoring by the Hospital's nursing or other staff, which is reasonable and necessary to evaluate an outpatient's condition, or to determine the need for a possible admission to the Hospital as an inpatient. This is normally less than a 24-hour period but can extend to 48 hours if Medically Necessary. Observations extending longer than 48 hours will be considered as an inpatient confinement and will require precertification

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization for the treatment of Mental Disorders and Substance Use Disorders means an Outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment typically consists of 3 to 6 hours per day for 5 days per week, however the frequency and length of treatment sessions may vary. Partial Hospitalization does not include a charge for room and board since the patient lives at home or in another environment.

Patient Care Services are defined as health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services do not include any of the following:

- An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
- Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
- Costs associated with managing the research associated with the Qualified Clinical Trial, or
- Costs that would not be covered for non-investigational treatments, or
- Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
- The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician is a provider that is licensed by the state medical board in the jurisdiction in which the services are provided, such as a medical or dental doctor or surgeon, audiologist, chiropodist, chiropractor, licensed professional counselor, masters level social worker, midwife, nurse practitioner, optometrist, osteopath, Physician's assistant, physical or occupational therapist, podiatrist, psychiatrist, psychologist, and speech therapist, to the

extent that such persons, within the scope of their license, are permitted to perform services covered by the Plan. A Physician shall not be a Plan Participant or any close relative of the Plan Participant.

Plan means Carolinas HealthCare System LiveWELL Health Plan, which is a benefits plan for certain Employees of Carolinas HealthCare System and is described in this document.

Plan Participant is any Employee, Spouse or Dependent who is covered under this Plan.

Plan Year means the 12-month plan year that is disclosed in the Summary Plan Description and in the Form 5500 Filing, if applicable.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prenatal Care. Care related to Pregnancy before birth, excluding labor, birth/delivery and post-delivery.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Psychiatric Rehabilitative Treatment Facility. A qualified provider of psychiatric rehabilitative treatment:

- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Hospital under Defined Terms.

A **Qualified Clinical Trial** is defined as a Phase I at CHS, Phase II, III or IV clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat a patient who has been diagnosed with cancer, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   - one of the United States National Institutes of Health (NIH), or
   - a cooperative group or center of the NIH, or
   - a qualified nongovernmental research entity identified in guidelines issued by the NIH for center support grants, or
   - the United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption, or
   - the United States Departments of Defense or Veterans Affairs, or
   - a qualified Institutional Review Board. (See also *Defined Terms*.)
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
7. The clinical trial does not unjustifiably duplicate existing studies, and
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient; i.e., is not designed exclusively to test toxicity or disease pathophysiology.

Coverage is provided only for costs of services associated with the trials and only to the extent such costs have not been or are not funded by other resources.

The Plan may require a copy of the Qualified Clinical Trial's study protocol, including the patient consent packet, before determining if any benefits are payable by the Plan. (*See* also *Patient Care Services*.)

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential Treatment. Residential Treatment for Mental Disorders and Substance Use Disorders is a rehabilitation program where services are provided in a temporary living arrangement similar to a Skilled Nursing Facility but in which 24-hour nursing services are provided to a patient who is not an immediate danger to self or others, and who needs this structure to maintain his or her current recovery level as determined by a qualified provider of psychiatric rehabilitative treatment.

Residential Treatment Facility. *See definition of Hospital*.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- Its services are provided for compensation and under the full-time supervision of a Physician.
- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialty Pharmacy is a program provided through the pharmacy benefit manager, or a preferred pricing arrangement with a Network provider. See Prescription Drug Benefits, Limitations and Exclusions.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Telemedicine is the practice of medicine using electronic communications, information technology or other means between a Physician in one location and a patient in another physical location. Telemedicine typically involves secure videoconferencing or store-and-forward technology that replicates the traditional Physician-patient interaction.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means:

- In the case of an Employee, an actual or perceived impairment that substantially limits one or more major life activities of the Employee. Total Disability is determined by the employer.
- In the case of a Dependent, an actual or perceived impairment that substantially limits one or more major life activities of the Dependent.

Usual, Customary and Reasonable (UCR). *See section entitled Coverage of Medical Expenses.*

HIPAA PRIVACY STANDARDS

The Plan and those administering it will use and disclose health information only as allowed by federal law. Set forth below is the Plan's Notice of Privacy Practices.

Compliance with HIPAA Privacy Standards
This Notice of Privacy Practices describes how
Medical information about you may be used and disclosed
and how you can get access to this information.
Please review it carefully.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA*) and the *Health Information Technology for Economic and Clinical Health Act (HITECH Act).* Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1) your past, present, or future physical or mental health or condition;
2) the provision of health care to you; or
3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator, as designated in your Summary Plan Description.

EFFECTIVE DATE
This Notice is effective August 15, 2013.

OUR RESPONSIBILITIES
We are required by law to:
- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION
Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine

benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Plan Sponsor protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law- enforcement official in response to a court order, subpoena, warrant, summons, or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- and about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice / authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. In most situations, we send mail to the employee / member. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy;
- or is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at the following website: ***http://www.medcost.com/***

To obtain a paper copy of this notice, contact the Plan Administrator.

QUESTIONS AND COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Health Plan Director or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

If you have a complaint, question, concern, or require a copy of the Privacy Notice, please contact Carolinas Healthcare System Benefits Administration at (704) 631-0263.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Regulations generally do not 'preempt' (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, mental health, Substance Use Disorders/Chemical Dependency, genetic testing, and reproductive rights.

CAROLINAS HEALTHCARE SYSTEM

Appendix A

MENTAL HEALTH AND SUBSTANCE USE DISORDERS BENEFITS

The Plan Participant should call Carolina Behavioral Health Alliance (CHBA) at (800) 475-7900 to receive certification for services for the treatment of mental health or substance use disorders. CBHA will ensure that all Plan Participants receive necessary and appropriate care while avoiding unnecessary expenses.

Carolina Behavioral Health Alliance (CBHA) is a Third Party Administrator contracted by the Plan to administer and pay claims for mental health and substance use disorders benefits. CBHA is a network of mental health and substance use disorders providers including Licensed Professional Counselors (LPC), Licensed Psychologists (PhD), Licensed Psychological Associates (LPA), Licensed Clinical Social Workers (LCSW), Licensed fee-based Practicing Pastoral Counselors (CFBPPC) and Licensed Substance Use Disorders Counselors (LSUDC). When you call CBHA, a trained and licensed mental health or substance use disorders professional will answer your call. He or she will discuss your problem and make a referral for evaluation, counseling or treatment to a Network Provider. Referrals are based on your needs and the Provider's availability and experience with your kind of problem.

Network Provider Plan
You have complete freedom of choice and may seek care from a Non-Network Provider; however, benefits will be paid at a lower coinsurance if you receive treatment for a Non-Network Provider. All Network Provider services are paid based on the Plan's allowed amount and Non-Network Provider services are paid based on usual and customary rates. The usual and customary rate may be substantially less than the Provider's actual charge. If you receive treatment from a Network Provider, you will only be responsible for your copay or co-insurance plus deductible. If you receive treatment from a Non-Network Provider, you will be responsible for charges above the usual and customary rate, in addition to any copayments, deductibles and applicable coinsurance (except in emergency situations).

This Plan has entered into an agreement with certain Hospitals, Physicians and other mental health and substance use disorders healthcare providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Note: To obtain Mental Health and Substance Use Disorders services from Network Providers, you must use Carolina Behavioral Health Alliance's Network. You can find a list of these providers at ***www.cbhallc.com*** or call (800) 475-7900.

Under the following circumstances, the Network payment will be made for certain Non-Network services:
- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network service area.
- If a Plan Participant is out of the Network service area and has a Medical Emergency requiring immediate care.
- If a Plan Participant receives the services of a Non-Network Provider in a Network facility, when the Plan Participant is not given the opportunity to specify or request the services of a Network Provider.
- If a Plan Participant receives Non-Network services and the provider has accepted a negotiated discount.

Note: Whether you choose a Network or Non-Network Provider, all services, except emergency room visits and Non-Network outpatient psychotherapy / medication management visits require precertification.

Precertification of Mental Health and Substance Use Disorders Services is not a guarantee of coverage or payment. CBHA management is designed only to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Payable benefits will depend on your eligibility for coverage, the Plan's limitations and exclusions and medical necessity.

Mental Health and Substance Use Disorders Management Services include:
- Utilization Review
  - Precertification
  - Concurrent Review
  - Discharge Planning
- Outpatient Review
- Enhanced Care Management

Utilization Review for Mental Health and Substance Use Disorders Services
Utilization Review is a set of formal methods designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers or facilities. All Mental Health and Substance Use Disorders benefits are subject to Utilization Review.

If a particular course of treatment or service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for reimbursement under the Plan. The enrollee is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification for Mental Health and Substance Use Disorders Services
The following services must be precertified before mental health or substance use disorders services are provided:

- Acute Hospital Admissions (except for emergencies)
- 48 Hour Observation Bed
- Partial Hospital Admission
- Intensive Outpatient Program Admissions
- Psychological Testing
- Inpatient and Outpatient ECT
- In-Network Outpatient Services
- Home Visits by a Behavioral Health Provider
- Psychological Evaluations for Bariatric Surgery

If there is an emergency admission to a facility, the enrollee, enrollee's family member, or the facility must contact CBHA within 48 hours of the admission or by the first business day after the admission whichever is later.

Mental Health and Substance Use Disorders Enhanced Care Management
Members who have two inpatient admissions in 6 months, have completed substance detoxification or meet other established criteria will be offered enrollment in the Enhanced Care Management program. Participation is voluntary. Once a member chooses to participate, CBHA will contact the member at regular intervals for one year. At each call, a CBHA clinical care manager will complete a survey to measure improvement since the last contact. If the member has had an increase in symptoms or symptom severity, the clinical care manager will coordinate care with the member's provider(s) and seek appropriate resources. CBHA will maintain regular contact with the member's provider(s) to assure that the member continues to be involved in treatment. There is no charge to the member for these services.

Filing Behavioral Health Claims
CBHA allows network providers 180 days from the date of service to file a clean claim. A clean claim is a claim that contains sufficient accurate information for the claim to be processed. Out-of-Network claims must be received within one year from the date of service. The time limit for filing a claim may be extended to 18 months from the date of service if documentation is submitted substantiating that the claimant was not reasonably or legally capable of filing the claim within the prescribed filing time limit.

Enrollees filing claims for Out-of-Network Services must submit a CBHA Claim Form accompanied by materials containing complete information to process the claim. The CBHA Claim Form is found on the CBHA website at ***www.cbhallc.com***. Enrollees may reach a CBHA claims representative at (800) 475-7900 to obtain assistance in filing Out-of-Network claims.

Deductibles and out-of-pockets maximums are applicable to combined medical and behavioral health benefits. There are no separate deductible or out-of-pocket maximums for behavioral health benefits. Refer to Plan provisions specifying amounts applicable to deductibles and out-of-pocket maximums.

Mail Mental Health and Substance Use Disorders claims to:
CBHA
PO Box 571137
Winston-Salem, NC 27157-1137

Mental Health and Substance Use Disorders Services
Plan Exclusions

Charges for the following are not covered:

Acupuncture; acupressure, hypnosis, hypnotherapy, biofeedback, massage therapy.

Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences, consultations or therapy sessions via internet except for Telemedicine conferencing.

Ambulance services are not covered under the mental health and substance use disorders benefits of the plan.

Appointments. Charges for broken or missed appointments.

Complications arising from non-covered services or treatment. No benefits are payable for any care, treatment, services or supplies, whether or not prescribed by a Physician, for complications from a non-covered condition.

Concurrent Care. The same service provided by more than one provider concurrently or a single provider providing the same service more than once in the same day. An exception is made to cover concurrent care that is precertified by CBHA as Medically Necessary for the treatment of the patient.

Cosmetic surgery (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons

Custodial care. Services and supplies, including confinement, that are provided to an individual primarily to assist with his/her daily living activities. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing oneself, dressing oneself, eating and taking medications. The Plan will not pay for Hospital care, nursing home or Skilled Nursing facility care, home care, or a school or other institution for behavior and/or developmental modification or care, or any other service that is custodial or respite care in nature

Developmental Disorders and Learning Disorders. The behavioral health portion of the plan will not pay for services for treatment for developmental disorders, communication disorders or learning disabilities.

Disorders of Infancy or Early Childhood. The plan does not cover treatment for Intellectual Developmental Disorders, Learning Disorders, Motor Skills Disorders, Communication Disorders, Pervasive Developmental Disorders, Feeding and Eating Disorders of Infancy or Early Childhood, Tic Disorders, Elimination Disorders, Stereotypic Movement Disorder or Disorders of Infancy, Childhood or Adolescence not otherwise specified in the absence of a covered mental illness.

Educational or Informational Sessions for relatives. Sessions for relatives of a patient receiving Mental Health or Substance Use Disorders treatment that are conducted for educational or informational purposes,

Educational or vocational testing. Services for educational or vocational testing or training.

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is in excess of the CBHA allowed amount.

Experimental and/or Investigational. Experimental or Investigational means any supply, medicine, facility, equipment, service, or treatment that:

- Is not currently or at the time the charges were incurred recognized as acceptable medical practice by the Plan as determined by CBHA Medical Management staff or qualified outside medical reviewers.
- A drug or device that must have Food and Drug Administration (FDA) approval for those specific indications and methods of use for which such drug or device is sought to be provided, subject to medical judgment of CBHA Medical Management staff or qualified outside medical reviewers.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.

Holistic or homeopathic medicine.

Hospital employees. The Plan will not pay for services billed directly by any person (Physician, nurse, therapist, etc.) who is an employee of a Medical Care facility and whose services are paid by the Medical Care facility.

Lack of Licensure. Services by a provider that is not licensed to provide the services rendered in the place where the services occurred.

Mandated or Court-Order Care. The Plan will not pay for any medical, psychological or psychiatric care that is the result of a court order or mandated by a third party (such as, but not limited to your Employer, licensing board, recreation council or school), unless it is Medically or psychologically Necessary, or court-ordered pursuant to a Qualified Medical Child Support Order

Marital or pre-marital counseling.

No charge. Confinement, treatment or services for which the Plan Participant has no financial liability or that would be provided at no charge in the absence of insurance coverage or for which the Plan has no legal obligation to pay.

Not specified as covered. Non-traditional services, treatments and supplies which are not specified as covered under this Plan.

Nutritional Counseling/Programs. Care and treatment of obesity, weight loss or dietary control, whether or not related to an illness, is not covered under the Behavioral Health Benefits of the Plan. Also excluded are nutritional consultations, recreation therapy, education therapy, self-help training and supplies. *Please refer to medical benefits for more information.*

Occupational. Care and treatment of an Illness that is occupational, that is, arises from work for wage or profit including self-employment. The Plan will not pay if you are eligible to receive payment under a Worker's Compensation law or similar legislation, regardless of whether or not you make a claim or receive compensation.

Plan design excludes. Charges excluded by the Plan design as described in this document.

Reimbursement. Treatments received or expenses incurred by a Plan Participant that are reimbursed, entitled to reimbursement, or are in any way indemnified by or through any public program except when this Plan is required by Federal Law to pay as primary. This exclusion includes confinement, treatment or services paid for or furnished by the United States Government or one of its agencies; but, does not apply to Medicaid or when otherwise prohibited by law.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Residential Treatment. Residential treatment for Mental Health and Substance Use Disorders is not covered for the following:

- The use of foster homes or halfway houses.
- For wilderness center training.
- For therapeutic boarding schools.
- For custodial care, situation or environmental change.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ended under this Plan.

Services for Secondary Conditions. Services rendered for secondary conditions, including V Codes, in the absence of a current illness or injury.

Sexual Dysfunctions. Charges for services due to sexual dysfunctions, sex transformation, sexual or gender identity disorders, non-congenital transsexualism, gender dysphoria or sexual reassignment or change are excluded. This Exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy for problems related to sexual dysfunction.

Sleep Disorders, Dementia and Neurological Disorders are excluded under the mental health and substance use disorders benefits.

Smoking Cessation/ Nicotine/Caffeine/Gambling Addiction or other process addiction, such as Internet usage or Sex. Care and treatment for smoking cessation, nicotine, caffeine or gambling addiction or other process addictions is not covered under the mental health and substance abuse benefits. *Please refer to medical benefits for more information.*

Special Education. The Plan does not pay for any form of special education such as music therapy, remedial reading, recreational or activity therapy, or equipment or supplies used similarly.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as *specifically* stated in this *Summary Plan Description*.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or for service related charges incurred while serving in the armed forces of any country except for Post-Traumatic Stress Disorder (PTSD).

Mental Health and Substance Use Disorders Services
Schedule of Benefits

Please refer to the *Schedule of Benefits* listed in the front of this Summary Plan Description (under *Mental Health and Substance Use Disorders)* for coverage of benefits of the Employee Group Health Plan provided by your Employer. The basis of payment of the benefits will be determined by the provider of services and claims rules of the Plan. All benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the determination that care and treatment is Medically Necessary; that charges are Usual, Customary and Reasonable; and that services, supplies and care are not Experimental and/or Investigational.

All Mental Health and Substance Use Disorders Services must be precertified by CBHA by calling (800) 475-7900.
