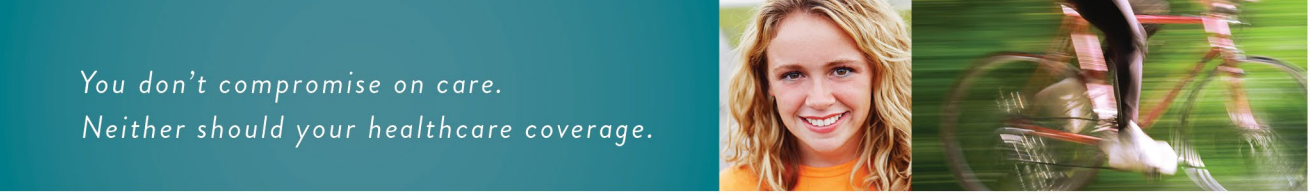

North Carolina Dental Society

Healthcare Plan

Plan Summary

Effective January 1, 2024

NORTH CAROLINA
DENTAL SOCIETY®

HEALTHCARE PLAN

FOR MEMBERS OF THE

NORTH CAROLINA DENTAL SOCIETY

AND THEIR EMPLOYEES

IMPORTANT CANCELLATION INFORMATION: Please read the provision entitled Termination of Coverage found on Page 30, and the provision entitled Plan Amendment and Termination found on Page 73.

Claims Administered
by
Interactive Medical Systems

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FOREWORD

The North Carolina Dental Society sponsors the Plan. The Plan is a self-funded medical plan.

The Plan Supervisor supervises the operation of the Plan. The Plan Supervisor has the discretionary authority to interpret all provisions of this Plan. The Claims Administrator processes claims.

This booklet describes medical benefits under the Plan. This booklet applies for Coverage Periods beginning on or after January 1, 2024. Some provisions are effective sooner, as specified in this booklet.

The Dental Society reserves the right to amend or terminate the Plan at any time and for any reason. Amendments are subject to the requirements of applicable laws.

Your employer may stop participating in this Plan. Your employer may also change its contributions to the cost of Plan coverage.

THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST FUND ESTABLISHED BY THE NORTH CAROLINA DENTAL SOCIETY. THE TRUST FUND IS CALLED "THE NORTH CAROLINA DENTAL SOCIETY HEALTHCARE PLAN TRUST FUND." A LICENSED INSURANCE COMPANY PROVIDES EXCESS LOSS INSURANCE TO COVER HIGH AMOUNT MEDICAL CLAIMS.

THE TRUST FUND IS NOT SUBJECT TO ANY INSURANCE GUARANTY ASSOCIATION. THE TRUST FUND IS MONITORED BY THE NORTH CAROLINA DEPARTMENT OF INSURANCE. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE NORTH CAROLINA DENTAL SOCIETY HEALTHCARE PLAN TRUST FUND. SUBSCRIBERS WILL BE RESPONSIBLE FOR FUNDING ALL CLAIMS COVERED UNDER THE TRUST.

IF THIS PLAN IS TERMINATED AND THE TRUST IS UNABLE TO FUND THE COST OF BENEFITS INCURRED TO THE DATE OF TERMINATION, THE TRUST MAY ASSESS SUBSCRIBERS TO THE EXTENT NECESSARY TO COVER SUCH COST.

The Plan will give you an Identification Card. You should present your card to any Hospital or provider of medical services. You may request additional cards for your covered Dependents.

This booklet is intended solely as a guide to help explain your benefits. If your circumstances are not described in this booklet, contact the Plan Supervisor. If you do not understand something described in this booklet, contact the Plan Supervisor.

A separate Trust agreement contains rules that apply to the Trust Fund. A separate Plan Participation Agreement contains rules that apply to your participation in the Plan. Copies of these agreements are available from the Plan Supervisor without charge.

IMPORTANT PARTICIPANT OBLIGATIONS

You must tell your employer of any change that may affect your eligibility. Also, you must tell your employer of any change that may affect your Dependent's eligibility. Please see the provision entitled "Notifying the Plan of Changes Affecting Eligibility" beginning on page 25.

Your failure to promptly notify your employer of a change may result in an avoidable loss of coverage. It may also prevent you or your Dependent from exercising important rights. For example, you might lose the right to elect continuation coverage or the right to enroll a new dependent.

PROVIDING IMMEDIATE OR PROMPT NOTICE

The provisions of this Plan sometimes require a person or group to provide immediate or prompt notice of an event or change in circumstance. In those cases, the notice will be considered timely if it is provided within two business days of the event or change in circumstance. If the Plan does not specify a due date, the notice will be considered late if it is not provided within 15 business days of the event or change in circumstance.

FALSE OR MISLEADING STATEMENTS

No person shall present any written or oral statement or other information to the Plan that such person knows or should know contains false or misleading information or that such person knows or should know omits material information. Under North Carolina law, it is a felony for any person, with the intent to injure, defraud or deceive an insurer, to present any written or oral statement in support of a claim for payment or other benefit knowing that the statement contains false or misleading information concerning any fact or matter material to the claim. It is also a felony to assist, abet or conspire with another person to prepare or make any statement that is intended to be presented to an insurer in connection with or in support of such a claim or benefit.

The Plan, the Plan Supervisor and the Plan's Trustees reserve all rights under state and federal law to protect the Plan against persons who make false and misleading statements in support of claims for payment or other benefits. Among other rights, the Plan may: recover benefits improperly paid; deny benefits to any person who is not eligible to participate; or deny benefits if the facts do not support payment under the terms of this Plan.

The Plan shall also have the right to rescind coverage of any individual whose act, practice or omission constitutes fraud with respect to the Plan or an intentional misrepresentation of material fact, subject to the requirements of applicable laws. The Plan will provide the affected individual with at least 30 days' advance written notice before implementing the retroactive rescission of coverage.

FACTS ABOUT THE PLAN

NAME OF THE PLAN:	North Carolina Dental Society Healthcare Plan (Also referred to as the Plan)
PLAN SUPERVISOR:	North Carolina Services for Dentistry, Inc. c/o Interactive Medical Systems PO Box 1349 Wake Forest, NC 27588 (877) 900-6237
PLAN SPONSOR:	North Carolina Dental Society 1600 Evans Road Cary, NC 27513 (919) 677-1396
TYPE OF PLAN:	Self-Funded Multiple Employer Welfare Arrangement providing Health Care Benefits.
TYPE OF ADMINISTRATION:	The Plan is supervised by the Plan Supervisor. The Plan Supervisor contracts with the Claims Administrator for processing of benefit claims and related recordkeeping services. Claims are paid from the Plan Trust Fund.
PLAN NUMBER:	2369
PLAN ADMINISTRATOR:	For purposes of ERISA and COBRA, the participating employer is the "plan administrator" with respect to the coverage provided to its Employees through this Plan. However, your employer may designate one or more of its Employees to serve as the "plan administrator" with respect to such coverage.
CLAIMS ADMINISTRATOR:	Interactive Medical Systems (IMS) PO Box 1349 Wake Forest, NC 27588 (877) 900-6237
PPO	MedCost P.O. Box 25307 Winston-Salem, NC 27114-5307 (800) 722-2157
PRESCRIPTION DRUG NETWORK	OptumRx Network ("OptumRx") (800) 788-7871 (for coverage verification) (888) 543-1369 or www.optumrx.com (Customer Service)

SUMMARY SCHEDULE OF BENEFITS
Plan B, Plan C, Plan D

The benefits provided by the Plan will be determined in accordance with the following schedules and subject to all Plan conditions, exclusions and limitations set out in this booklet.

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN B

The following is a Summary of Benefits for PPO Plan B. For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the sections entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and Limitations. Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage (not applicable to Prescription Drugs)	**In-Network**	**Out-of-Network**
Annual Deductible: (see page 38 for more information)	**Single:** $2,000 **Family:** $6,000	**Single:** $4,500 **Family:** $13,500
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs)**:**	**Single:** $6,000 **Family:** $12,000	**Single:** $10,000 **Family:** $20,000
Insured Percentage: (unless otherwise expressly stated)	70%	50%

General Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit: (see page 8 for more information on Standard Preventive Care)	$25 Co-Pay (Standard Preventive Care covered 100% and Deductible waived unless billed or tracked separately)	50%, subject to the Deductible
Specialist Office Visit:	70%, subject to the Deductible	50%, subject to the Deductible
Urgent Care Facilities:	70%, subject to the Deductible	50%, subject to the Deductible
Emergency Services: *(The Deductible is waived for the initial emergency room treatment of an accidental Injury, provided the services are rendered within 72 hours of the accident causing the Injury)*	70%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	70%, subject to the Deductible	50%, subject to the Deductible
Diagnostic X-Ray and Laboratory other than Standard Preventive Care:	$25 Co-Pay	50%, subject to the Deductible

General Services	In-Network	Out-of-Network
(for services billed separately from the Physician office visit)		
Pre-Admission Testing: **(performed on an outpatient basis)**	70%, subject to the Deductible	50%, subject to the Deductible

Standard Preventive Care	In-Network	Out-of-Network
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	Not Covered, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms: (see page 54 for more information)		
Colonoscopy and Colorectal Cancer Screening: (For adults over age 45)		
Other Services Qualifying as Standard Preventive Care: (see page 8 for more information)		

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Per Confinement Deductible:	$0	$250
Inpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Outpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Maternity/Delivery:	70%, subject to the Deductible	50%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only

Extended Supply - OptumRx Prescription Drug Card: (mail order for 32 to 90 day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$10 Co-Pay for generic $100 Co-Pay for formulary brand names $140 Co-Pay for non-formulary brand names
Short Term Supply - OptumRx Prescription Drug Card: (retail; maximum 31-day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$5 Co-Pay for generic $50 Co-Pay for formulary brand names $70 Co-Pay for non-formulary brand names $200 Co-Pay for specialty

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	70%, subject to the In-Network Deductible	
Skilled Nursing Facility:	70%, subject to the Deductible	50%, subject to the Deductible
Durable Medical Equipment:	70%, subject to the Deductible	50%, subject to the Deductible
Hearing Aids and Related Services and Supplies: (for covered participants and dependents under the age of 22; limited to $2,500 per hearing aid every 36 months)	70%, subject to the Deductible	50%, subject to the Deductible
Home Health Care:	70%, subject to the Deductible	50%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Infusion Therapy:	70%, subject to the Deductible	50%, subject to the Deductible
Hospice:	70%, subject to the Deductible	50%, subject to the Deductible
Physical Therapy, Spinal Manipulation/Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	70%, subject to the Deductible	50%, subject to the Deductible
TMJ:	70%, subject to the Deductible	50%, subject to the Deductible
Mental Health: (other than Standard Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible
Chemical Dependency: (other than Standard Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN B CO-PAY PROVISIONS

Services rendered in the Primary Physician's Office: Most covered services provided by a Network Primary Care Physician in his or her office are subject to a $25 co-pay. There is no Deductible and the usual Coinsurance is not required.

If the services rendered in the primary Physician's office constitute Standard Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed. However, the office visit Co-Pay is not waived if the Standard Preventive Care is billed separately or is tracked as independent encounter data separately; or if the primary purpose of the office visit is not the delivery of Standard Preventive Care.

In-Network Lab and X-ray Services: In-Network lab and x-ray services that are billed separately from the Physician office visit will be subject to a separate $25 Co-Pay. If these services constitute Standard Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed.

Services not included under the Office Visit Co-Pay: The office visit Co-Pay does not apply to some services. For example:

- The Co-Pay does not apply to Prescription Drugs;
- The Co-Pay does not apply to Cancer Treatments; and
- The Co-Pay does not apply to Physical, Speech, and Occupational Therapy.

These services are subject to the Plan Deductible and Coinsurance requirement. Also, they are subject to Plan exclusions and limitations.

PLAN B STANDARD PREVENTIVE CARE

In-Network Standard Preventive Care services and supplies are not subject to Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. Standard Preventive Care is defined beginning on page 70.

Under Plan B, Standard Preventive Care includes laboratory screening for diabetes and certain diabetic equipment and supplies (i.e., insulin pumps and supplies for insulin pumps).

The Plan Deductible and Coinsurance percentage will apply if the primary purpose of the office visit is not the delivery of Standard Preventive Care. If the Standard Preventive Care is billed separately or tracked as independent encounter data separately, the Plan deducible and Coinsurance percentage will apply to services that are not Standard Preventive Care.

PLAN B MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Standard Preventive Care is not covered. Mandated Benefits are covered in the same manner as In-Network Standard Preventive Care. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  - Is at least the age specified by the preventative care guidelines (currently age 45); or
  - At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).

Mandated Benefits are subject to the limitations and provisions of the section entitled "Covered Charges for Health Care Benefits" beginning on page 51.

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN C

The following is a Summary of Benefits for PPO Plan C. For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the sections entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and Limitations. Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage	In-Network	Out-of-Network
Annual Deductible (see page 38 for more information)**:**	**Single:** $3,000 **Family:** $6,000	**Single:** $6,000 **Family:** $12,000
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs)**:**	**Single:** $6,000 **Family:** $12,000	**Single:** $10,000 **Family:** $20,000
Insured Percentage (unless otherwise expressly stated):	70% after Deductible	50% after Deductible

General Services	In-Network	Out-of-Network
Primary Care Physician Office Visit: (see page 12 for more information on Standard Preventive Care)	70%, subject to the Deductible (Standard Preventive Care covered 100% and Deductible waived unless billed or tracked separately)	50%, subject to the Deductible
Specialist Office Visit:	70%, subject to the Deductible	50%, subject to the Deductible
Urgent Care Facilities:	70%, subject to the Deductible	50%, subject to the Deductible
Emergency Services:	70%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	70%, subject to the Deductible	50%, subject to the Deductible
Diagnostic X-Ray and Laboratory other than Standard Preventive Care: (for services billed separately from the Physician office visit):	70%, subject to the Deductible	50%, subject to the Deductible
Pre-Admission Testing: (performed on an outpatient basis)	70%, subject to the Deductible	50%, subject to the Deductible

Standard Preventive Care	In-Network	Out-of-Network
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	Not Covered, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms: (see page 54 for more information)		
Colonoscopy and Colorectal Cancer Screening: (For adults over age 45)		
Other Services Qualifying as Standard Preventive Care: (see page 12 for more information)		

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Inpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Outpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Maternity/Delivery:	70%, subject to the Deductible	50%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only
OptumRx Prescription Drug Card (retail or mail order): *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy.	100%, subject to the In-Network Deductible

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	70%, subject to the In-Network Deductible	
Skilled Nursing Facility:	70%, subject to the Deductible	50%, subject to the Deductible
Durable Medical Equipment:	70%, subject to the Deductible	50%, subject to the Deductible
Hearing Aids and Related Services and Supplies: (for covered participants and dependents under the age of 22; limited to $2,500 per hearing aid every 36 months)	70%, subject to the Deductible	50% subject to the Deductible
Home Health Care:	70%, subject to the Deductible	50%, subject to the Deductible
Infusion Therapy:	70%, subject to the Deductible	50%, subject to the Deductible
Hospice:	70%, subject to the Deductible	50%, subject to the Deductible
Physical Therapy, Spinal Manipulation/Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Mental Health: (other than Standard Preventive Care)	Office Visit: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
	Inpatient/Outpatient: 70%, subject to the Deductible	Inpatient/Outpatient: 50%, subject to the Deductible
TMJ:	70%, subject to the Deductible	50%, subject to the Deductible
Chemical Dependency: (other than Standard Preventive Care)	Office Visit: 70%, subject to the Deductible Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN C STANDARD PREVENTIVE CARE

In-Network Standard Preventive Care services and supplies are not subject to Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. Standard Preventive Care is defined beginning on page 70.

Under Plan C, Standard Preventive Care includes laboratory screening for diabetes and supplies for insulin pumps (but not for insulin pumps or other items or services for treatment of diabetes).

The Plan Deductible and Coinsurance percentage will apply if the primary purpose of the office visit is not the delivery of Standard Preventive Care. If the Standard Preventive Care is billed separately or tracked as independent encounter data separately, the Plan deducible and Coinsurance percentage will apply to services that are not Standard Preventive Care.

PLAN C MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Standard Preventive Care is not covered. Mandated Benefits are covered in the same manner as In-Network Standard Preventive Care. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  - Is at least the age specified by the preventative care guidelines (currently age 45); or
  - At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).

Mandated Benefits are subject to the limitations and provisions of the section entitled “Covered Charges for Health Care Benefits” beginning on page 51.

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN D

The following is a Summary of Benefits for PPO Plan D.

For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the sections entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and Limitations.

Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage (not applicable to Prescription Drugs)	**In-Network**	**Out-of-Network**
Annual Deductible: (see page 38 for more information)	**Single:** $6,000 **Family:** $12,000	**Single:** $10,000 **Family:** $20,000
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs)**:**	**Single:** $8,000 **Family:** $16,000	**Single:** $12,000 **Family:** $24,000
Insured Percentage: (unless otherwise expressly stated)	60% after Deductible	40% after Deductible

General Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit: (see page 18 for more information on Standard Preventive Care)	$25 Co-Pay (waived for Standard Preventive Care unless billed or tracked separately)	40%, subject to the Deductible
Specialist Office Visit:	$75 Co-Pay (waived for Standard Preventive Care unless billed or tracked separately)	40%, subject to the Deductible
Urgent Care Facilities:	$75 Co-Pay	40%, subject to the Deductible
Emergency Services: *(The Deductible is waived for the initial emergency room treatment of an accidental Injury, provided the services are rendered within 72 hours of the accident causing the Injury)*	$500 Co-Pay (waived if admitted); remaining charges paid at 100%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	60%, subject to the Deductible	40%, subject to the Deductible
Diagnostic X-Ray and Laboratory other than Standard Preventive Care: **(for services billed separately from the Physician office visit)**	60%, subject to the Deductible	40%, subject to the Deductible

General Services	In-Network	Out-of-Network
Pre-Admission Testing: **(performed on an outpatient basis)**	60%, subject to the Deductible	40%, subject to the Deductible

Standard Preventive Care	In-Network	Out-of-Network
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	Not Covered, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms: (see page 54 for more information)		
Colonoscopy and Colorectal Cancer Screening: (For adults over age 45)		
Other Services Qualifying as Standard Preventive Care: (see page 18 for more information)		

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Inpatient:	60%, subject to the Deductible	40%, subject to the Deductible
Outpatient:	60%, subject to the Deductible	40%, subject to the Deductible
Maternity/Delivery:	60%, subject to the Deductible	40%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only
Extended Supply—OptumRx Prescription Drug Card: (mail order for 32 to 90 day supply) * Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$20 Co-Pay for generic $200 Co-Pay for formulary brand names 60%, subject to the Deductible non-formulary brand names
Short Term Supply—OptumRx Prescription Drug Card: (retail; maximum 31-day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$10 Co-Pay for generic $100 Co-Pay for formulary brand names 60%, subject to the Deductible for non-formulary brand names $250 Co-Pay for specialty

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	60%, subject to the In-Network Deductible	
Skilled Nursing Facility:	60%, subject to the Deductible	40%, subject to the Deductible
Durable Medical Equipment:	60%, subject to the Deductible	40%, subject to the Deductible
Hearing Aids and Related Services and Supplies: (for covered participants and dependents under the age of 22; limited to $2,500 per hearing aid every 36 months)	60%, subject to the Deductible	40%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Home Health Care:	60%, subject to the Deductible	40%, subject to the Deductible
Infusion Therapy:	60%, subject to the Deductible	40%, subject to the Deductible
Hospice:	60%, subject to the Deductible	40%, subject to the Deductible
Physical Therapy, Spinal Manipulation/Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	60%, subject to the Deductible	40%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	60%, subject to the Deductible	40%, subject to the Deductible
TMJ:	60%, subject to the Deductible	40%, subject to the Deductible
Mental Health: (other than Standard Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 60%, subject to the Deductible	Office Visit: 40%, subject to the Deductible Inpatient/Outpatient: 40%, subject to the Deductible
Chemical Dependency: (other than Standard Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 60%, subject to the Deductible	Office Visit: 40%, subject to the Deductible Inpatient/Outpatient: 40%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN D CO-PAY PROVISIONS

Services rendered in the Primary Physician's Office: Most covered services provided by a Network Primary Care Physician in his or her office are subject to a $25 co-pay. There is no Deductible and the usual Coinsurance is not required.

If the services rendered in the primary Physician's office constitute Standard Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed. However, the office visit Co-Pay is not waived if the Standard Preventive Care is billed separately or is tracked as independent encounter data separately; or if the primary purpose of the office visit is not the delivery of Standard Preventive Care.

Services not included under the Office Visit Co-Pay: The office visit Co-Pay does not apply to some services. For example:

- The Co-Pay does not apply to Prescription Drugs;
- The Co-Pay does not apply to Cancer Treatments; and

- The Co-Pay does not apply to Physical, Speech, and Occupational Therapy.

These services are subject to the Plan Deductible and Coinsurance requirement. Also, they are subject to Plan exclusions and limitations.

PLAN D STANDARD PREVENTIVE CARE

In-Network Standard Preventive Care services and supplies are not subject to Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. Standard Preventive Care is defined beginning on page 70.

Under Plan D, Standard Preventive Care includes laboratory screening for diabetes and certain diabetic equipment and supplies (i.e., insulin pumps and supplies for insulin pumps).

The Plan Deductible and Coinsurance percentage will apply if the primary purpose of the office visit is not the delivery of Standard Preventive Care. If the Standard Preventive Care is billed separately or tracked as independent encounter data separately, the Plan deducible and Coinsurance percentage will apply to services that are not Standard Preventive Care.

PLAN D MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Standard Preventive Care is not covered. Mandated Benefits are covered in the same manner as In-Network Standard Preventive Care. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  - Is at least the age specified by the preventative care guidelines (currently age 45); or
  - At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).

Mandated Benefits are subject to the limitations and provisions of the section entitled "Covered Charges for Health Care Benefits" beginning on page 51.

SPECIAL PROVISIONS APPLICABLE TO ALL PLAN OPTIONS

Under each of the Plan options, Emergency Services received from an out-of-network provider shall be paid at the In-Network level.

A special rule applies if you are treated at a Network facility, and your primary Physician or surgeon while you are in the facility is also In-Network. In that case, the Covered Charges from other Physicians may be paid at the In-Network level of benefit.

Special COVID-19 Coverage: Coverage for office visits, urgent care, and emergency room visits for the testing and diagnosis of COVID-19, as well as coverage for the testing and diagnosis of COVID-19, will be offered under all Plan options without any cost-sharing (such as deductibles, copayments, and coinsurance). Coverage for immunization of COVID-19 will be offered under all Plan options without any cost-sharing.

This Summary Schedule of Benefits is only a summary of what the Plan covers. You can find more information on the following pages.

ELIGIBILITY

A participant or his covered Dependent who incurs Covered Charges because of Illness or Injury will be eligible for the Health Care Benefits provided by this Plan. Coverage is subject to the terms and conditions set forth in this Plan Summary, including the Exclusions and Limitations beginning on page 58. The Plan will cover or reimburse Covered Charges for Health Care Benefits only if coverage is in effect for the participant or Dependent at the time the charges are incurred. Covered Charges are incurred at the time services are rendered.

ELIGIBLE GROUPS

Group coverage under the Plan is available only for eligible groups. An entity or sole proprietorship that is engaged in a trade or business within the sphere of dentistry will be an eligible group if it satisfies two requirements. First, at least one dentist must be a shareholder, partner or owner of the business. Second, each dentist who is a shareholder, partner, owner or employee of the trade or business must be an active member of the Plan Sponsor.

Group coverage under the Plan is also available to the Plan Sponsor and its subsidiaries.

A Participating Employer must sign a Plan Participation Agreement.

EMPLOYEES

The term “Employee” means any employee of the Participating Employer who is regularly scheduled to work on a full-time basis in its trade or business. The Plan will treat you as a full-time employee if you are regularly scheduled to work a certain number of hours in the normal work week of your Participating Employer. Your Participating Employer will specify the minimum number of hours in its Plan Participation Agreement. If your Participating Employer failed to specify the minimum number of hours in its Plan Participation Agreement, the Plan will treat you as a full-time employee if you are regularly scheduled to work 16 or more hours in a normal work week.

If you are absent from work due to temporary sickness or temporary disability, the Plan will still treat you as an Employee so long as you remain employed by the Participating Employer in a full-time position. However, you will cease to be a full-time Employee under the Plan after a continuous absence from work of 90 days.

Independent contractors are not Employees for purposes of this Plan.

The term “Employee” also includes a self-employed dentist practicing full-time for a Participating Employer.

> Special COVID-19 Eligibility Rule: If you are furloughed or have a reduction in hours due to COVID-19 the Plan will still treat you as an Employee until the day after your "initial eligibility date" described in WHEN DO EMPLOYEES BECOME ELIGIBLE FOR COVERAGE? if you meet the following requirements:
>
> - You were employed on March 10, 2020, and,

- As of that date, you were scheduled to work a sufficient number of hours to become eligible to enroll in the Plan.

If you are treated as an Employee pursuant to the above, then you may enroll in the Plan on your normal eligibility date even if you experience a reduction of hours (including a furlough) due to the COVID-19 pandemic that would otherwise result in your not being eligible for enrollment. If, following your enrollment, you are no longer treated as an Employee due to your reduction in hours or other qualifying event, then the plan's continuation of coverage provisions will apply.

WHEN DO EMPLOYEES BECOME ELIGIBLE FOR COVERAGE?

As a new Employee, you are eligible after satisfying the eligibility waiting period. This is your "initial eligibility date". If your Participating Employer failed to specify the number of days in the eligibility waiting period in its Plan Participation Agreement, the eligibility waiting period is deemed to be 30 days from your date of hire.

If you decline coverage when you first become eligible, you may not enroll until the next Open Enrollment period. If you wait more than 30 days after your initial eligibility date to apply for coverage, you may not enroll until the next Open Enrollment period. If earlier, you may enroll 18 months after your initial eligibility date or the date you are entitled to enroll under the section "Special Enrollee" below.

If you do not enroll during an Open Enrollment period, you may not enroll until the next Open Enrollment period. If earlier, you may enroll 18 months after the Open Enrollment period in which you failed to enroll or the date you are entitled to enroll under the section "Special Enrollee" below.

Your coverage will begin on your initial eligibility date, if you submit a proper application to the Plan Supervisor within 30 days of the initial eligibility date. If you are enrolling during an Open Enrollment period, your coverage will begin on the next following Anniversary Date.

An Employee whose coverage has commenced under this Plan may be referred to in this Plan Summary as a "participant" or "member" of the Plan.

DEPENDENTS

As a member of this Plan, you may cover your eligible Dependents.

Eligible Dependents are listed below:

- Your spouse (as determined for federal tax purposes);
- Your children who are under age 26 years of age, regardless of their student or marital status. For purposes of this Plan, "children" include your sons, daughters, stepsons and stepdaughters. An individual you have legally adopted, or who has been lawfully placed with you for adoption, or who is a foster child placed with you by an authorized placement agency (or by judgment, decree or other order of a court) will be treated as your child;
- Any person under age 19 who is related to you by blood or marriage and for whom you are the legal guardian;

- Any child who is required to be covered pursuant to a Qualified Medical Child Support Order as an eligible Dependent under the Plan;
- Any mentally handicapped or physically handicapped unmarried child who is age 26 or older, provided such child:

  (1) is your child as defined above;
  (2) is incapable of self-sustaining employment;
  (3) is dependent on you for more than one-half of his or her support;
  (4) is ineligible for coverage under any other group health insurance arrangement; and
  (5) became mentally handicapped or physically handicapped before reaching the age of 19.

If you want to continue to cover your mentally handicapped or physically handicapped child, it will be necessary to submit proof that the retardation or handicap began before he or she reached age 19. Proof of retardation or handicap will be required no more than once per year.

If a person is an eligible Dependent of more than one Employee, only one Employee may cover the person as a Dependent.

A Dependent child's spouse, children or other dependents are not eligible Dependents under this Plan.

WHEN DO DEPENDENTS BECOME ELIGIBLE?

Your Dependent will not be eligible for coverage until his or her eligibility date. Your Dependent's "eligibility date" is the later of the date your coverage begins, or the date he or she becomes your Dependent.

For purposes of this Plan, the eligibility date for an adopted or foster child under the age of 26 is the later of the date your coverage begins and the date the child is placed in your home for adoption or foster care (even though the adoption may not yet be final).

The eligibility date for your newborn child shall be the later of the date your coverage begins and the child's date of birth.

Your Dependent's coverage will begin as of his or her eligibility date, if you submit a proper application to the Plan within 30 days of the eligibility date. If you are enrolling a Dependent during an Open Enrollment period, his or her coverage will begin on the next following Anniversary Date.

If you do not enroll your Dependent within 30 days after the Dependent's eligibility date, you may not enroll the Dependent until the next Open Enrollment period. If earlier, you may enroll 18 months after the Dependent's eligibility date or the date you are entitled to enroll the Dependent under the section "Special Enrollee" below.

If you do not enroll your Dependent during an Open Enrollment period, you may not enroll the Dependent until the Plan's next Open Enrollment period. If earlier, you may enroll 18 months

after the Open Enrollment period in which you failed to enroll the Dependent or the date you are entitled to enroll the Dependent under the section "Special Enrollee" below.

Each newly added Dependent must enroll for a minimum of twelve months. In other words, if you add a Dependent to the Plan, you will be required to pay premiums for that Dependent for at least twelve months. However, the Plan may terminate the Dependent's coverage as described in the "Termination of Coverage" section of this booklet. Also, if you do not pay premiums for your Dependent on time, the Plan reserves the right to not pay claims for that Dependent.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A "medical child support order" is a child support order from a court of competent jurisdiction, which requires that a group health plan provide coverage for a dependent child of a participant if the plan normally provides coverage for dependent children. Typically these types of orders are generated as a part of a divorce proceeding or a paternity action. The Plan Supervisor is responsible for determining whether a medical child support order is qualified (a QMCSO) and applicable to the Plan. You may obtain a copy of the Plan procedures governing QMCSOs free of charge from the Plan Supervisor.

If this Plan receives a medical child support order, the Plan Supervisor will notify you and each child affected by the order.

If you receive a medical child support order as part of your divorce decree or as a result of a paternity suit, contact the Plan Supervisor immediately after receipt of your decree so that the Plan Supervisor may determine whether the order qualifies as a QMCSO.

RETIREE COVERAGE

An Eligible Retiree may convert from group to individual coverage under the Plan when he or she retires or terminates with a Participating Employer. An Eligible Retiree may also enroll his or her Dependents who were covered under the Plan at the time of the Eligible Retiree's retirement or termination.

An Eligible Retiree may maintain individual coverage for himself and his Dependents who were covered at the time of his or her retirement or termination, until the coverage expires. Coverage for a Retired Participant will expire on the day before his or her 65th birthday or, if earlier, as of the date he or she becomes eligible for coverage as a member or as a dependent under another group health plan. In the case of coverage under another group health plan, Plan coverage will expire even if the Eligible Retiree does not enroll in the other plan.

Retiree coverage is not available if the Plan Participant is not actively practicing with or actively employed by the Participating Employer when he or she reaches retirement age. A Participant who is an Eligible Retiree on account of continuous membership with the Plan Sponsor must continue active membership status with the Plan Sponsor for the duration of his or her coverage as a Retired Participant.

If the Retired Participant's coverage expires due to age, his or her covered spouse or other Dependents may continue coverage until the Dependent coverage expires. This coverage will

expire on the date the spouse attains age 65. Also, coverage for a spouse or other Dependent shall terminate as of the date he or she becomes eligible for coverage as a member or as a dependent under another group health plan. However, if the Dependent is a child of the Retired Participant, the child's eligibility will continue until the child attains age 26, notwithstanding the spouse's age or the Dependent's eligibility for other coverage. In any case, the Dependent coverage is subject to the Termination of Coverage provisions as set forth on page 30 of this booklet.

A special rule applies to retired members of the Plan Sponsor who had retiree coverage under the Plan Sponsor's previous group health plan on December 31, 1999. They are eligible to continue as Retired Participants under this Plan through age 64. They can also cover their Dependents. However, to qualify for this coverage they must retain their active membership with the Plan Sponsor.

Another special rules applies to Dependent spouses who had retiree coverage under the Plan Sponsor's previous group health plan on December 31, 1999. They can continue such individual coverage under this Plan through age 64.

The Plan will treat a Retired Participant or other person maintaining individual coverage under this provision as a "member" or "Participant" for purposes of this Plan Summary.

GRANDFATHERED ELIGIBILITY FOR CERTAIN DISABLED PARTICIPANTS

A special rule applies to members of the Plan Sponsor who had coverage as disabled dentists under the Plan Sponsor's previous group health plan on December 31, 1999. They are eligible to continue their individual coverage under this Plan through age 64. They can also cover their Dependents. However, to qualify for this coverage they must retain their active membership with the Plan Sponsor. Also, this coverage will be available only so long as the member is disabled.

If the disabled dentist's coverage expires due to age, his or her covered spouse or other Dependents may continue coverage until the Dependent coverage expires. This coverage will expire on the date the spouse attains age 65. Also, coverage for a spouse or other Dependent shall terminate as of the date he or she becomes eligible for coverage as a member or as a dependent under another group health plan. However, if the Dependent is a child of the disabled dentist, the child's eligibility will continue until the child attains age 26, notwithstanding the spouse's age or the Dependent's eligibility for other coverage. In any case, the Dependent coverage is subject to the Termination of Coverage provisions as set forth on page 30 of this booklet.

The disabled dentist must secure available coverage under Medicare. The Plan will determine benefits for disabled dentists who are eligible for Medicare as if the disabled dentist were receiving Medicare benefits.

The Plan will treat a disabled person maintaining individual coverage under this provision as a "member" or "Participant" for purposes of this Plan Summary.

GRANDFATHERED ELIGIBILITY FOR CERTAIN SURVIVING SPOUSES AND OTHER DEPENDENTS

Notwithstanding the foregoing, if the requirements of this paragraph are satisfied the surviving spouse of a member of the North Carolina Dental Society may elect to convert his group coverage to individual coverage under the Plan (and may also convert coverage for his or her Dependents who were covered under the Plan at the participant's death) following the member's death. Such a surviving spouse may maintain individual coverage through the spouse's attainment of age 65 or remarriage (whichever occurs first), but only if such spouse was covered under Plan at the time of the member's death, and only if such spouse was covered under the Dental Society's previous group health plan as of December 31, 1999. A surviving spouse eligible for individual coverage under this provision may also cover the surviving spouse's Dependents who were covered under the Plan at the time of the member's death, but only so long as the spouse is eligible for individual coverage. Coverage for surviving spouses and their Dependents is subject to the Termination of Coverage provisions set forth on page 30 of this booklet. In addition, coverage for the spouse or other Dependent shall terminate as of the date the spouse or other Dependent becomes eligible for coverage under another group health plan or, if earlier, the date the spouse attains age 65. However, if the Dependent is a child of the deceased participant, the child's eligibility will continue until the child attains age 26, notwithstanding the surviving spouse's age and notwithstanding the Dependent's eligibility for other coverage. The spouse and other Dependents maintaining individual coverage under this Plan provision shall bear the entire expense of such coverage.

A surviving spouse maintaining individual coverage under this provision shall also be considered a "member" or "participant" for purposes of this Plan Summary.

PREMIUMS PAID FOR NON-ELIGIBLE PERSONS

The Plan will limit the refund of premiums paid for a non-eligible person to the premiums paid for the 90 days preceding the date the error is reported to the Plan Supervisor or its designee. The Plan will not pay interest on returned premiums. The Plan will not refund premiums paid for a non-eligible person to the extent the Plan has paid claims on behalf of such person for services rendered when the person was not eligible.

No Subscriber, Participating Employer, Participant or Dependent may elect to discontinue coverage retroactively under the Plan.

Clerical errors or delays in updating Plan records will not have the effect of extending coverage beyond the termination date determined by the terms of the Plan. If the Plan overpays a claim or pays a claim for a non-eligible person due to a clerical error, the person must return the overpayment or improper payment to the Plan.

NOTIFYING THE PLAN OF CHANGES AFFECTING ELIGIBILITY

Subscriber Obligation to Notify Plan Supervisor

The individual or group subscriber must notify the Plan Supervisor or its designee of changes that may affect a participant or Dependent's eligibility. The subscriber must provide the notice

in writing. The subscriber may provide the notice by telephone, but only if the subscriber provides written confirmation within 5 business days.

The subscriber must notify the Plan Supervisor or its designee immediately if: there is a change in a Participant's employment or marital status; there is a change in the number of a Participant's Dependents; there is a change in a Dependent's status; a Participant or Dependent retires or becomes disabled; a Participant or Dependent has a name or address change; there is a change in other medical coverage that a member of the Participant's family may have (including becoming entitled to Medicare or Social Security disability benefits); or there is any other change in status that would affect the Participant's eligibility or coverage or the eligibility or coverage of a Dependent.

A failure to promptly notify the Plan Supervisor of a change may result in a loss of coverage. It may also prevent a Participant or Dependent from exercising important rights. For example, a person might lose the right to elect continuation coverage or the right to enroll a new dependent. If the failure to notify causes the Plan to pay benefits to an ineligible person, the subscriber will be required to reimburse the Plan for all benefits for which the person was ineligible.

Employee/Participant Obligation to Notify Employer

You must tell your employer of any change that may affect your eligibility. Also, you must tell your employer of any change that may affect the eligibility of your Dependent. You may tell the Plan Supervisor or its designee directly. In any case, you must provide the notice in writing. You may provide the notice by telephone, but only if you provide written confirmation within 5 business days.

You must notify your employer or the Plan Supervisor or its designee immediately if: there is a change in your employment or marital status; there is a change in the number of your Dependents; there is a change in a Dependent's status; you or your Dependent retires or becomes disabled; you or your Dependent has a name or address change; there is a change in other medical coverage that a member of your family may have (including becoming entitled to Medicare or Social Security disability benefits); or there is any other change in status that would affect your eligibility or coverage or the eligibility or coverage of a Dependent.

Your failure to promptly tell your employer or the Plan Supervisor of a change may result in a loss of coverage. It may also prevent you or your Dependent from exercising important rights. For example, you might lose the right to elect continuation coverage or the right to enroll a new dependent. If your failure to notify causes the Plan to pay benefits to an ineligible person, you will be required to reimburse the Plan for all benefits for which the person was ineligible.

SPECIAL ENROLLMENT

Employee or Dependent Losing Other Coverage

The Plan shall permit an Employee who is eligible, but not enrolled, for coverage under the terms of the Plan (or a Dependent of the Employee if the Dependent is eligible, but not enrolled,

for coverage under the terms of the Plan) to enroll for coverage under the terms of the Plan if each of the following conditions is met:

- the individual was covered under an ERISA group health plan or had health insurance coverage ("Other Coverage") at the time coverage under this Plan was previously offered to him;
- the employee stated in writing at the time that the Other Coverage was the reason for declining enrollment (provided that the Plan Supervisor or participating employer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time);
- the individual's Other Coverage (a) was under a COBRA continuation provision and such coverage was exhausted, or (b) was not under a COBRA continuation provision and at least one of the following applies: (i) the Other Coverage was terminated because of loss of eligibility for the coverage, including legal separation, divorce, cessation of dependent status, death, termination of employment or reduction in hours of employment, or any loss of eligibility for coverage after a period measured by reference to any of the foregoing events; (ii) employer contributions toward the cost of the Other Coverage were terminated; (iii) the individual lost the Other Coverage because the individual no longer resided, lived, or worked in the service area (whether or not by the individual's choice) if the Other Coverage was offered through an arrangement that did not provide benefits to individuals who no longer reside, live, or work in such service area, and no other benefit package is available to the individual; (iv) the individual incurs a claim that would meet or exceed the Other Coverage's lifetime limit on all benefits; (v) the Other Coverage no longer offers any benefits to the class of similarly situated individuals that includes the individual; or (vi) the health insurer terminated the Other Coverage under Section 58-68-45(c)(2) of the North Carolina General Statutes; and
- under the terms of the Plan, the Employee requests the enrollment not later than 30 days after the applicable event described above.

New Dependents

If an Employee of a participating employer is a participant in the Plan (or has met any waiting period applicable to becoming a participant in the Plan and is eligible to be enrolled in the Plan but for a failure to enroll during a previous enrollment period), and a person becomes an eligible Dependent of that individual by reason of marriage, birth, or adoption or placement for adoption or foster care:

- such person may be enrolled under the Plan as a Dependent of the individual;
- if not otherwise enrolled as a participant, the individual may be enrolled under the Plan as a participant; and
- in the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a Dependent of the individual if the spouse is otherwise eligible for coverage.

The special enrollment period shall be the 30 days beginning on the date of marriage, birth, adoption or placement for adoption or foster care. If an individual enrolls himself or a Dependent during this special enrollment period, the coverage shall become effective (i) in the case of marriage, as of the date of marriage; (ii) in the case of a Dependent's birth, as of the date

of birth; or (iii) in the case of a Dependent's adoption or placement for adoption or foster care, as of the date of adoption or placement for adoption or foster care.

If an Employee of a participating employer is a participant in the Plan (or has met any waiting periods applicable to becoming a participant in the Plan and is eligible to be enrolled in the Plan but for a failure to enroll during a previous enrollment period), and the Employee is required by a court or administrative order to provide health benefit plan coverage for a child, the Employee may enroll the child without regard to any enrollment period restrictions. If the Employee is not already enrolled as a participant, the Employee must also enroll himself or herself at the same time. If the Employee fails to enroll the child in the Plan pursuant to a court or administrative order, the Plan will enroll the child (and the Employee, if the Employee is not already enrolled as a participant) upon application of the child's non-employee parent or the Department of Health and Human Services. The Plan will not disenroll or eliminate coverage for the child unless satisfactory written evidence is provided that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

Please note that unless coverage otherwise terminates in accordance with the "Termination of Coverage" section of this booklet, each newly added Dependent must enroll for a minimum of twelve (12) months. In other words, if you add a Dependent to the Plan, you will generally be required to pay premiums for that Dependent for at least a twelve (12) month period beginning on the date coverage for the Dependent begins under the Plan. Notwithstanding the foregoing, if premiums for such a Dependent are delinquent, the Plan reserves the right to pay or not pay claims relating to such a Dependent.

Special Enrollment Rights Under the Children's Health Insurance Program Reauthorization Act (CHIPRA)

An individual may have the right to enroll in the Plan mid-year in the event an Employee or his or her eligible Dependent (1) loses coverage under Medicaid or a state child health program, or (2) becomes eligible for state assistance with respect to paying his or her contributions to the Plan. The Plan will provide special enrollment rights in the following situations:

- *Employee's loss of coverage under Medicaid or a state children's health insurance program:* If an Employee is not participating in the Plan and the Employee loses coverage under Medicaid or a state children's health insurance program, the Employee may enroll himself or herself and any eligible Dependents (including the spouse) in the Plan. However, the request for enrollment must be made within 60 days after the government-provided coverage ends.
- *Dependent's loss of coverage under Medicaid or a state children's health insurance program:* If an Employee's Dependent (including the spouse) is not participating in the Plan and the Dependent loses coverage under Medicaid or a state children's health insurance program, the Employee may enroll that Dependent in the Plan. However, the request for enrollment must be made within 60 days after the government-provided coverage ends.
- *Becoming eligible for state premium assistance subsidy:* If an Employee or Dependent (including the spouse) is not participating in the Plan and the individual becomes eligible for

state assistance in paying for coverage under the Plan (either through Medicaid or a state children's health insurance program), that individual may enroll in the Plan. However, the request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

COVID-19 Special Enrollment Rule

The period beginning on March 1, 2020 and ending 60 days after the announced end of the coronavirus National Emergency (or such other date announced by the applicable government agencies) will be disregarded in calculating the deadline for exercising any special enrollment right described above.

TERMINATION OF COVERAGE

EMPLOYEES AND COVERED DENTAL SOCIETY MEMBERS

Your health care coverage will terminate on the earliest of the following dates:

- The date on which you cease to be a full-time Employee of your employer (unless you are continuing coverage under the Plan's retiree coverage provisions);
- The date on which your eligibility for retiree or disability coverage expires;
- The date the Plan is amended to terminate the coverage of a class of Employees or other persons of which you are a member;
- The date you, your Dependent or your participating employer has performed an act of fraud or intentional misrepresentation of material fact in connection with a claim for eligibility or benefits under the terms of the Plan;
- If you or your employer fail to make any required contribution, and contributions are being paid on a monthly basis, the tenth (10th) day of the month for which the contribution was due;
- If you or your employer fail to make any required contribution, and contributions are being paid on a quarterly basis, the thirty first (31st) day following the first day of the quarter for which the contribution was due;
- The date your employer terminates its participation in the Plan;
- The date your employer is no longer an eligible group (e.g., your employer is no longer engaged in a trade or business within the sphere of dentistry); or
- The date the Plan is terminated.

DEPENDENTS

Coverage for Dependents ends on the earliest of the following dates:

- The date your coverage ends;
- The date you stop participating in the Plan;
- The date a Dependent ceases to be a Dependent (for example, he or she reaches the age limit);
- In the case of a Dependent who is your spouse, the date of your divorce;
- The date the Plan is amended to terminate Dependent coverage;
- If you, your employer, or your Dependent fail to make any required contribution, and contributions are being paid on a monthly basis, the tenth (10th) day of the month for which the contribution was due;
- If you, your employer, or your Dependent fail to make any required contribution, and contributions are being paid on a quarterly basis, the thirty first (31st) day following the first day of the quarter for which the contribution was due;
- The date on which the Dependent's eligibility for survivor coverage expires;
- The date you fail to provide to the Plan Supervisor or its designee required information on the status of your mentally handicapped or physically handicapped Dependent children as required herein;
- The date your employer terminates its participation in the Plan; or
- The date the Plan is terminated.

The Plan will not terminate coverage for any Dependent on account of the Dependent ceasing to be a full-time student.

CONTINUATION OF BENEFITS

State Continuation. For group subscribers, North Carolina law requires the Plan to provide continuation coverage under certain circumstances following a participant or Dependent's loss of coverage. Generally speaking, these rules, which are described below, apply to participating employers with fewer than 20 employees. These provisions do not apply to subscribers maintaining individual coverage under the Plan as permitted under the provisions for Retiree Coverage, Disabled Participant coverage or coverage for Surviving Spouses and Other Dependents of Plan Participants following death.

Continuation of coverage applies only to persons who have been continuously covered under the Plan, and any similar group benefits the Plan replaces, for at least 3 months.

The Plan will continue any such coverage in force for a participant or Dependent on the date group coverage would otherwise end for any reason except failure to pay any required contributory premium.

But, coverage will not be continued:

- if any discontinued coverage is replaced by similar group coverage; or
- if the person is, or could be covered, by any other group coverage providing Hospital, surgical or medical benefits.

The participant or a family member has the responsibility to inform the participating employer of a divorce or a child losing Dependent status under the Plan within 60 days of the date of the event. Your employer has the responsibility to notify the Plan Supervisor or its designee of the Employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement, and to notify the Plan Supervisor or its designee when it learns of a divorce or a child losing Dependent status under the Plan.

An individual eligible to elect continuation coverage under the Plan may do so by notifying the participating employer (in writing by completing a form provided by the Plan Supervisor) and paying to the participating employer the required premium (unless the participating employer elects to pay the premium for the individual), all within 60 days of the date the individual's coverage would otherwise end. If continuation coverage is elected, the participating employer will continue to carry the individual as a covered member of its group, and so long as the participating employer pays the premiums on a timely basis, such continuation coverage will be retroactive to the date the electing individual would have otherwise lost coverage. If the individual does not choose continuation coverage on a timely basis, or fails to pay the required premium to the participating employer, or the participating employer fails to remit the required premium to the Plan on a timely basis, coverage under the Plan will end effective as of the date that individual's coverage would otherwise terminate.

Coverage may be continued for 18 months provided the participant and/or Dependents pay to the participating employer the required premium for the continued coverage. The premium for the

continued coverage shall be the same as the current premium under the Plan for such participant and Dependents. Dependents electing Continuation due to reaching age 26, will pay the current premium for like individuals. The participating employer may require that the premium be paid by each covered person in advance, but not less often than monthly.

Continued coverage will end at the earliest of:

- the end of the 18-month continuation period;
- the end of a period for which premiums have been paid, if the covered person fails to pay the premium when due;
- the end of a period for which premiums have been paid, if the participating employer fails to remit to the Plan the premium when due;
- the date the Plan is terminated;
- the date Plan participation for the employer of the covered person is terminated for any reason;
- the date the covered person is eligible to be covered for similar benefits on a group basis; or
- for a Dependent, the date his or her coverage would end because he or she is no longer an eligible Dependent unless the reason for Continued coverage is reaching age 26.

Continued coverage for the participant and his covered Dependents shall be available for up to 11 additional months following the 18 month continuation period, *but only if:*

- The Social Security Administration determines, under Title II or XVI of the Social Security Act, that the participant has been disabled at any time during the first 60 days of the participant's continued coverage;
- The participant notifies both the participating employer and the Plan Supervisor or its designee of such determination prior to the date continued coverage would otherwise end; and
- The participant provides a copy of the Social Security determination to the Plan Supervisor or its designee prior to the date continued coverage would otherwise end.

If the Plan replaces another group policy, a covered person with continued coverage under the prior policy may continue coverage under the Plan for the remaining period of continuation to which he or she is entitled.

COBRA

This section will apply if your participating employer had more than 20 employees on a typical business day in the preceding calendar year. In such a case, federal continuation coverage rules under the Consolidated Omnibus Budget Reconciliation Act, or COBRA, will apply. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also

become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this summary booklet, or contact your employer (your employer will designate itself or one of its Employees as the "plan administrator" for purposes of this section).

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's

becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify its plan administrator within 30 days of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. As noted above, your employer has designated itself or one of its Employees as the plan administrator, and your employer will let you know how to provide this notice.

How is COBRA Coverage Provided?

Once your plan administrator receives notice that a qualifying event has occurred, your plan administrator will offer COBRA continuation coverage to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify your plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide a copy of the Social Security determination to your plan administrator within 60 days after the date of the disability determination, and before the end of the initial 18-month period of continuation coverage. In addition, your plan administrator must provide a copy of the Social Security determination to the Plan Supervisor promptly after receiving it from you. The Plan will not extent COBRA continuation coverage unless you and your plan administrator meet these deadlines.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your plan administrator. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide written notice of the qualifying event to your plan administrator within 60 days after the date of the event, and before the end of the initial 18-month period of continuation coverage. In addition, your plan administrator must provide written notice of the qualifying event to the Plan Supervisor promptly after receiving it from you. The Plan will not extent COBRA continuation coverage unless you and your plan administrator meet these deadlines.

Deadline for COBRA Elections and Securing COBRA Coverage from the Plan

As noted above, when the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your employer must notify its plan administrator within 30 days of the qualifying event. The plan administrator then has 14 days to notify qualified beneficiaries of their COBRA election rights. Qualified beneficiaries have only 60 days after receiving this notice to elect COBRA continuation coverage.

The participating employer or its plan administrator must notify the Plan Supervisor whenever a qualified beneficiary elects COBRA continuation coverage under the Plan, and must provide to the Plan Supervisor such documentation as the Plan Supervisor may request. This Plan will not provide COBRA continuation coverage to a qualified beneficiary unless the participating employer or its plan administrator provides a copy of the qualified beneficiary's election to the Plan Supervisor:

- no later than the 120th day after the date of the qualifying event, when the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or
- promptly after receiving the qualified beneficiary's election in the case of any other qualifying event (however, continuation coverage will be denied if the qualified beneficiary has not properly notified the participating employer or its plan administrator of the qualifying event within the time limit specified in this Plan).

This Plan will not provide an extension of COBRA continuation coverage on account of disability or a second qualifying event unless the qualified beneficiary provides notice of the disability or second qualifying event in accordance with the Plan's terms.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your plan administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your plan administrator and the Plan Supervisor or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator or to the Plan Supervisor.

SPECIAL COVID-19 RULES REGARDING CONTINUATION OF COVERAGE

For all qualified beneficiaries, in determining the deadline to elect COBRA continuation coverage, to notify the plan of a qualifying event or determination of disability, and whether monthly COBRA premium installment payments are timely, the period beginning March 1, 2020, and ending 60 days after the announced end of the COVID-19 National Emergency or such other date announced by the applicable government agencies, will be disregarded. The period disregarded in any particular case will not be more than one year.

CERTIFICATE OF CREDITABLE COVERAGE

This Plan is required to furnish a certificate of creditable coverage to covered individuals to provide documentation of the individual's prior creditable coverage. This certification will include the period of creditable coverage of the individual under the Plan and any coverage under the COBRA continuation provision, and any waiting period and affiliation period imposed with respect to the individual for any coverage under the Plan.

A certificate of creditable coverage:

- must be provided automatically by the Plan Supervisor (a) when an individual either loses coverage under the Plan or becomes entitled to elect COBRA continuation of coverage, and (b) when an individual's COBRA continuation coverage ceases; and
- must also be provided upon request by the individual, provided the individual makes the request within 24 months after losing coverage or termination of COBRA coverage.

The Plan Supervisor or its designee will automatically provide a certificate of creditable coverage in accordance with Paragraph (1) above, or will provide a certificate upon request in accordance with Paragraph (2) above.

GUARANTEED RENEWABILITY OF COVERAGE

Coverage must renew or remain in force at the option of the participating employer. However, the Plan may discontinue coverage with respect to a participating employer and its Employees and their Dependents based on one or more of the following:

- Nonpayment of premiums – the participating employer has failed to pay premiums or contributions or the Plan has not received timely premium payments.
- Fraud – the participating employer has performed an act of fraud or intentional misrepresentation of material fact under the terms of the Plan.
- Violation of participation or contribution rules – the participating employer has failed to comply with the provisions of the Plan or applicable law relating to employer contributions or group participation rules.
- Termination of a particular type of coverage – The Plan ceases to offer a particular type of coverage in the market, provided that the Plan Supervisor or Sponsor provides notice of such discontinuation to each participating employer, participant and Dependent covered under the Plan at least 90 days before the date of discontinuation.
- Termination of all coverage – The Plan ceases to offer coverage in the market, provided that the Plan Supervisor or Sponsor provides notice of such discontinuation to the Commissioner of Insurance and to each participating employer, participant and Dependent covered under the Plan at least 180 days before the date of discontinuation.
- Association membership ceases – A shareholder, partner, or owner of the participating employer ceases to be an active member of the North Carolina Dental Society for any reason, or the participating employer for any reason ceases to be eligible to participate under the terms of the Plan.

TERMINATION OF EMPLOYER GROUP COVERAGE

If a Participating Employer terminates its participation in the Plan, the Plan will provide written notice of termination to all affected members.

HEALTH CARE BENEFITS

BENEFIT DEDUCTIBLE AND COINSURANCE PERCENTAGE

The Deductible is the amount you must pay for Covered Charges each Coverage Period before the Plan starts to pay benefits. (See the Summary Schedule of Benefits beginning on page 4.) There are separate Deductibles for In-Network and out-of-network benefits. Amounts applied toward your out-of-network Deductible do not apply toward your In-Network Deductible. Amounts applied toward your In-Network Deductible do not apply toward your out-of-network Deductible.

There are two types of Deductibles – individual and family. If you elect family coverage under Plan B, or Plan D each family member must meet the applicable individual Deductible if the related family Deductible has not been met. For family coverage under Plan C, the entire family Deductible must be met before Covered Charges are paid by the Plan. Deductible amounts satisfied during a Coverage Period do not carry over to any subsequent Coverage Period.

Once the Deductible for the Coverage Period has been satisfied, the Plan will pay Covered Charges subject to the applicable Coinsurance percentage indicated in the Summary Schedule of Benefits until the applicable Out-of-Pocket Limit is met. Once the applicable Out-of-Pocket Limit for the Coverage Period has been met, the Plan will pay 100% of the balance of Covered Charges, subject to the limitations indicated in the Summary Schedule of Benefits. If you elect family coverage, then each family member must meet the applicable individual Out-of-Pocket Limit if the related family Out-of-Pocket Limit has not been met. Amounts applied toward your out-of-network Coinsurance or Out-of-Pocket Limit do not apply toward your In-Network Coinsurance or Out-of-Pocket Limit. Amounts applied toward your In-Network Coinsurance or Out-of-Pocket Limit do not apply toward your out-of-network Coinsurance or Out-of-Pocket Limit.

NOTICE: Your actual expenses for covered services may exceed the applicable Coinsurance percentage or co-payment amount because actual Provider charges may not be used to determine Plan and participant/beneficiary payment obligations.

COPAYMENT

A copayment is the amount of money that is paid each time a particular service is used.

UTILIZATION MANAGEMENT

This Plan has a "Utilization Management" program. This is a way for the Plan to monitor health care, including the use of health care services and supplies, health care settings and the levels of care. It is also a way for the Plan to evaluate medical necessity, appropriateness, efficacy or efficiency of medical care. The Plan's utilization management procedures are described in detail beginning on page 77.

Pre-certification Review

This Plan's utilization management program requires pre-certification of certain Hospital admissions and Outpatient procedures. If your Provider recommends admission to the Hospital, you must get the Plan's approval before the admission. Note that any Hospital stay or confinement longer than 48 hours will be treated as an admission for purposes of the pre-certification requirement.

Also, you must get the Plan's approval before any Outpatient surgical procedure.

The Plan's pre-certification procedures are described in detail beginning on page 78.

When you ask the Plan for pre-certification of a Hospital admission or Outpatient surgery, the PPO will evaluate the medical information and the proposed care based on professional standards of medical care. The PPO will tell your Provider what the Plan will cover and the date of any subsequent review. The PPO may provide this information verbally, if permitted by law. The PPO will provide the information in writing if required by the Plan, by State or federal regulations or by external accrediting bodies.

If you have an Emergency Medical Condition requiring Emergency Services, including services relating to maternity care, pre-admission certification is not required, but you or your Physician should contact the PPO as soon as possible following stabilization of your condition.

IMPORTANT NOTE REGARDING PRE-ADMISSION CERTIFICATION: If you fail to get pre-certification when the Plan requires it, the Plan will reduce benefits that are otherwise payable by $250.

Inpatient Review

The Plan concurrently reviews Hospital care to determine medical necessity and the need for continued care, to facilitate discharge planning, and to assure timely and efficient care. The Plan's procedures for conducting concurrent care reviews are described in detail beginning on page 79.

Retrospective Review

The Plan may conduct a retrospective review when it learns of services already provided for a Hospital admission or Inpatient or Outpatient procedure. A retrospective review is a review of medically necessary services and supplies that is conducted after services have been provided to a patient. The Plan's procedures for conducting retrospective care reviews are described in detail beginning on page 80.

Standard Data Elements

In order to make decisions, the Plan may request certain clinical and other relevant information. You or your Provider must provide any such information reasonably requested by the Plan. This may include pertinent clinical data, information about care Providers and details about requested care. Pertinent clinical data may include patient history, admission dates, procedures or

treatments, lab results, diagnosis, treatment plan, second opinions, discharge planning and any related information or documentation. The Plan is also entitled to information on Providers, such as the type of Provider, location, contact details, staffing, capacity, etc.

Occasionally after making a reasonable effort, the Plan may not have the necessary information to make a coverage determination. For this purpose, reasonable effort is defined as a minimum of three attempts within one (1) business day for services already being rendered or to be provided within the next two (2) or three (3) days. For services scheduled farther in advance, reasonable effort is defined as a minimum of three (3) or more attempts within three (3) business days.

Utilization Management Determinations

If the Plan or the PPO determines that services, supplies or other items are covered under the Plan, the Plan or PPO will not subsequently retract such determination after the services, supplies or other items have been provided, or reduce payments for a service, supply or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the claimant's health condition that was knowingly made by the claimant or the provider of the service, supply or other item.

Disclosure of Utilization Management Criteria

Participating providers, covered persons and bona fide prospective participants may receive the following upon request:

- An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by covered or prospective covered persons. The explanation may be in writing if so requested;
- Written reasons for denial of recommended treatments and an explanation of the clinical review criteria or treatment protocol upon which the denial was based; and
- The Plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is Experimental.

LARGE CASE MANAGEMENT

"Case Management" is utilization review for care needed by a patient with a serious, complicated, or protracted health condition. Case Management provides cost effective alternatives in reducing costs.

Your PPO provides Case Management for the Plan. If the Plan, the claimant, and the Provider agree on the most cost-effective treatment modality assuring quality medical care, the Plan will provide benefits for only such services.

If your PPO identifies you as a candidate for Case Management, the PPO will contact you and ask you to participate in the program. If you fail to enroll and participate in Case Management or you do not comply with the program's recommendations, the Plan will reduce your benefits. The Plan will reduce your benefits by $1,000 before any Covered Charges related to the diagnosis that is the subject of Case Management will be paid. This penalty is in addition to the

Plan's annual Deductible and the unpaid charges will not accumulate towards the Out-of-Pocket limit. If you start complying with the Case Management program after a portion of the Case Management penalty has been applied to Covered Charges, the Plan will not apply the Case Management penalty to Covered Charges subsequently incurred. The Plan will not reconsider payment on any Case Management penalty imposed prior to your participation and compliance.

SELECT PROCEDURES REQUIRING PRIOR APPROVAL

The Plan requires pre-certification from your PPO for any elective Outpatient surgery performed outside of the Physician's office.

The Plan requires pre-certification from your PPO for any CT Scan, MRI, PET Scan or Varicose Vein Treatment performed on an Outpatient basis or in the Physician's office.

You should call the PPO whenever you have a question about whether a procedure or Hospital admission requires prior approval.

PREDETERMINATION OF SURGICAL BENEFITS

To eliminate any questions before any treatment has been performed, you may submit a Pre-Estimate of procedures and their costs to the Claims Administrator. A "Pre-Estimate" is the Physician's report that (a) itemizes his recommended services, (b) shows his charge for each service, and (c) is accompanied by supporting diagnostic records where required or requested by the Claims Administrator. This process allows both you and the Physician to confirm in advance what is covered and what are the estimated benefits.

SURGICAL BENEFIT

The Plan covers surgery performed in an Outpatient department of a Hospital or an ambulatory surgical center. The benefit is subject to the limitations set forth in the Summary Schedule of Benefits. Covered Charges will include Reasonable and Customary Physician's charges, facility fees, anesthesia, x-rays, lab fees and any other necessary charges incurred in relation to surgery performed on that day. The surgical benefit will not include prescription drugs purchased after the surgery. The Plan will cover such prescription drugs as described in the Summary Schedule of Benefits, and as described in the "Prescription Drug Plan" section.

Surgery performed on an Inpatient basis or in a Physician's office is also covered.

A special rule applies if an assistant surgeon must render technical assistance because the procedure cannot safely be performed by the primary surgeon. In that case, the Plan will consider benefits in an amount equal to the fee charged. However, the Plan will cover the additional charges only if such expenses are allowable as determined by the Claims Administrator after the primary surgeon's fee is paid.

A special rule applies if two or more surgical procedures are performed at one session and add significant time and complexity to the patient's care. In that case, the maximum allowable fee will be the fee for the major procedure with the highest limit, plus 50% of the fee that would apply for each other procedure if performed separately. If a second procedure is only incidental,

and is through the same incision, the maximum allowable fee will be the fee for the major procedure.

PRE-ADMISSION TESTING

When performed on an Outpatient basis, pre-admission testing will be included as a Covered Charge, subject to the appropriate Coinsurance requirements and other limitations set forth in the Summary Schedule of Benefits.

Testing must be performed within seven (7) days of a scheduled Hospital confinement and must be performed at the same Hospital where such confinement is to occur.

If covered pre-admission tests are repeated after the patient's admission to the Hospital as an Inpatient, the Plan will not cover any part of the cost for the repeated tests. However, this exclusion does not apply if the Hospital confinement was postponed due to medical necessity.

MENTAL ILLNESS

This Plan will pay benefits for Mental Illness treatments as described in this section. Such benefits are subject to the appropriate Coinsurance requirements and other limitations set forth in the Summary Schedule of Benefits. The Plan will only pay the necessary, Reasonable and Customary expenses for Mental Illness treatments ordered by a Physician.

- Inpatient Treatment: The Plan will pay expenses on the same basis as any other Illness. Benefits are subject to the appropriate Coinsurance requirements and other limitations set forth in the Summary Schedule of Benefits. The patient must be confined to a Hospital, a properly licensed psychiatric institution, or a Residential Treatment Facility.
- Outpatient Treatment: The Plan will pay for Outpatient treatments at the applicable Coinsurance rate set forth in the Summary Schedule of Benefits.

Durational limits for Mental Illness treatments shall be subject to the same limits as benefits for physical Illness generally.

ALCOHOLISM AND CHEMICAL DEPENDENCY

This Plan will pay benefits for the treatment of substance abuse as described in this section. Such benefits are subject to the appropriate Coinsurance requirements and other limitations set forth in the Summary Schedule of Benefits. The Plan will only pay the necessary, Reasonable and Customary expenses for the treatment of substance abuse ordered by a Physician. "Substance abuse" includes alcoholism and chemical dependency.

- Inpatient Treatment: The Plan will pay expenses on the same basis as any other Illness. Benefits are subject to the appropriate Coinsurance requirements and other limitations set forth in the Summary Schedule of Benefits. The patient must be confined to a Hospital, a properly licensed psychiatric institution, or a Residential Treatment Facility.
- Outpatient Treatment: The Plan will pay for Outpatient treatments at the applicable Coinsurance rate set forth in the Summary Schedule of Benefits.

THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

(For Employee and Dependent Spouse Only)

The Plan generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for a mother or her newborn child to less than 48 hours in the case of a vaginal delivery, and not less than 96 hours for the mother and newborn for a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ROUTINE NEWBORN BABY CARE

Charges for necessary services and supplies incurred for a covered newborn child during Hospitalization immediately following birth will be paid according to the Summary Schedule of Benefits for:

- Covered Charges for other services and supplies furnished by the Hospital for care;
- Physician charges for newborn care; and
- Covered Charges for circumcision.

If the member is covered under the Plan, the new child will be covered for routine well baby care from birth until discharge. If the newborn child is discharged before the minimum stay described above with respect to the Newborns and Mothers Health Protection Act, the baby may be eligible for coverage for follow-up routine well baby care as long as the care is received within 72 hours of discharge. In order for a newborn child to be covered past the initial well baby delivery Hospital stay period, you must add the child to the Plan as a covered Dependent in accordance with the rules described in the above sections entitled "When Do Dependents Become Eligible" and "Special Enrollee."

Foster children and adopted children shall be treated the same as newborn infants and eligible for routine newborn baby care on the same basis upon placement in the foster home or placement for adoption.

SMARTSTARTS

The Plan includes the MedCost "SmartStarts Maternity Management Program." This is a wellness program focused on educating expectant mothers and fathers and mentoring them through each trimester of pregnancy. The program is provided to Plan Participants at no additional cost.

Throughout pregnancy, Participants may call 1-800-722-2157 for immediate access to a prenatal nurse.

Pregnant Participants are required to enroll in the SmartStarts Maternity Management Program during the first trimester (14 weeks) and continue to participate until delivery. If you or your

spouse/partner are pregnant at the time of enrollment, you must enroll in SmartStarts within the first 30 days of coverage and continue to participate until delivery. If you are eligible for, but fail to enroll and participate in the SmartStarts Maternity Management Program or you do not comply with the program's recommendations, the Plan will reduce your benefits. The Plan will reduce your benefits by $1,000 for Covered Charges related to your pregnancy. This penalty is in addition to the Plan's annual Deductible and the unpaid charges will not accumulate towards the Out-of-Pocket limit. If you start complying with the program after a portion of the SmartStarts penalty has been applied to Covered Charges, the Plan will not apply the SmartStarts penalty to Covered Charges subsequently incurred. The Plan will not reconsider payment on SmartStarts penalties imposed prior to your participation and compliance.

To enroll, call 1-800-722-2157.

ROUTINE PHYSICAL EXAM

The Plan offers a Routine Physical benefit as provided in the Summary Schedule of Benefits. The benefit includes charges for X-rays, Lab tests, Prostate Screening, Mammograms, and Immunizations. Immunizations include the human papillomavirus (HPV) vaccine.

SUPPLEMENTARY ACCIDENT BENEFIT

The Plan will pay for Medically Necessary treatment of a non-Occupational Injury that occurs while the person is covered as a Participant or Dependent. Treatment must be ordered by, or given by, a Physician and benefits are payable according to the Plan provisions. If the Injury requires emergency room care, the Deductible is waived for the initial visit to the emergency room, provided the visit occurs within 72 hours of the accident causing the Injury.

Except as provided below, the Plan will not cover the treatment of Occupational Injury.

The Plan will pay up to $100,000 per incident for Medically Necessary treatment of Occupational Injury for a covered Employee of the Participating Employer, but only if the Employee is not covered by workers compensation insurance and only if the Occupational Injury is sustained in the course of the Employee's employment with the Participating Employer's dental practice. Treatment must be ordered by, or given by, a Physician and benefits are payable according to the Plan provisions. If the Injury requires emergency room care, the Deductible is waived for the initial visit to the emergency room, provided the visit occurs within 72 hours of the accident causing the Injury. The Plan will not cover a Dependent's Occupational Injury under any circumstances.

Total supplementary accident benefits paid shall not exceed the limit set forth in the Summary Schedule of Benefits, and will be subject to the coverage percentage shown in the Summary Schedule of Benefits.

FOREIGN TRAVEL

In many cases, charges for health care services provided outside the U.S. are not covered by the Plan. This is true not only for elective services but also emergency care. Because this Plan provides limited coverage outside the U.S., a Covered Person traveling abroad should consider

buying a travel medical expense insurance policy. An insurance agent or travel agent can provide more information about buying medical expense insurance. Note not all travel insurance includes health insurance, so it's important to read the conditions or restrictions carefully.

PRESCRIPTION DRUG PLAN

OptumRx is a national network with many participating pharmacies. To find a participating pharmacy near you, visit www.optumrx.com. When you use your card at a participating retail pharmacy, you will pay the applicable Co-Pay under Plan B or pay the full price less any available contracted discount for your covered prescription drugs under Plan C.

For a complete list of covered drugs, or if you have questions relating to your prescription drug coverage, call OptumRx at 888-543-1369; the toll-free member phone number found on your ID Card. Or visit www.optumrx.com.

If the pharmacist has a problem verifying your coverage, please have them contact OptumRx at 800-788-7871.

Prescription Drug Benefits for Plan B

You may use any participating pharmacy in the OptumRx network. You will pay a $5 co-pay for generic drugs, $40 co-pay for formulary brand name drugs or $60 co-pay for non-formulary brand name drugs. For a list of formulary drugs visit www.optumrx.com.

If you use a non-participating pharmacy, you will pay 100% of the prescription price. This expense will not be eligible for reimbursement by the Plan and will not count against Deductibles or Out-of-Pocket Limits.

The Plan will pay a maximum 31-day supply at a retail pharmacy. You must pay the Co-Pay for each month's supply dispensed. However, you can purchase a 90-day supply of medication through OptumRx's mail service program. You will pay only two Co-Pays for a three-month supply of medication through the mail order services.

If the prescribing Physician has indicated that a generic version of the drug may be dispensed, but you request that the prescription be filled with a brand name drug, you will pay the applicable Co-Pay for the brand prescription as described above, plus 100% of the difference in the retail cost between the generic and the brand name drug. This coverage penalty does not apply to the Out-of-Pocket Limit. If the prescribing Physician indicated that a brand name drug must be dispensed, you will pay the applicable Co-Pay for the brand prescription but will not be charged for the difference in cost between the generic and brand name drug.

You will need to present your NCDS Healthcare Plan ID card to the pharmacist and pay the applicable Co-Pay amount for your prescription.

Please note that if you have any of the conditions listed below, you must fill your prescriptions through the OptumRx Specialty Pharmacy, as described at www.optumrx.com.

Prescription Drug Benefits for Plan C

You may use any participating pharmacy in the OptumRx network. No coverage is provided for prescriptions filled at pharmacies that are not in this network.

After the annual Deductible is satisfied, the Plan will pay 100% of the cost of the prescription.

If the prescribing Physician has indicated that a generic version of the drug may be dispensed, but you request that the prescription be filled with a brand name drug, you will pay the applicable Deductible for the brand prescription as described above, plus 100% of the difference in the retail cost between the generic and the brand name drug. This coverage penalty does not apply to the Deductible or Out-of-Pocket Limit. If the prescribing Physician indicated that a brand name drug must be dispensed, you will pay the applicable Co-Pay for the brand prescription but will not be charged for the difference in cost between the generic and brand name drug.

You will need to present your NCDS Healthcare Plan ID card to the pharmacist and pay any Deductible amount for your prescription.

Please note that if you have any of the conditions listed below, you must fill your prescriptions through the OptumRx Specialty Pharmacy, as described at www.OptumRx.com.

Prescription Drug Benefits for Plan D

You may use any participating pharmacy in the OptumRx network. You will pay a $10 co-pay for generic drugs, $100 co-pay for formulary brand name drugs or 60% after deductible for non-formulary brand name drugs. For a list of formulary drugs visit www.optumrx.com.

If you use a non-participating pharmacy, you will pay 100% of the prescription price. This expense will not be eligible for reimbursement by the Plan and will not count against Deductibles or Out-of-Pocket Limits.

The Plan will pay a maximum 31-day supply at a retail pharmacy. You must pay the Co-Pay for each month's supply dispensed. However, you can purchase a 90-day supply of medication through OptumRx's mail service program. You will pay only two Co-Pays for a three-month supply of medication through the mail order services.

If the prescribing Physician has indicated that a generic version of the drug may be dispensed, but you request that the prescription be filled with a brand name drug, you will pay the applicable Co-Pay for the brand prescription as described above, plus 100% of the difference in the retail cost between the generic and the brand name drug. This coverage penalty does not apply to the Out-of-Pocket Limit. If the prescribing Physician indicated that a brand name drug must be dispensed, you will pay the applicable Co-Pay for the brand prescription but will not be charged for the difference in cost between the generic and brand name drug.

You will need to present your NCDS Healthcare Plan ID card to the pharmacist and pay the applicable Co-Pay amount for your prescription.

Please note that if you have any of the conditions listed below, you must fill your prescriptions through the OptumRx Specialty Pharmacy, as described at www.optumrx.com.

OptumRx Specialty Pharmacy

Drugs for certain conditions will be provided only through the OptumRx Specialty Pharmacy. These conditions are:

- Hepatitis C
- Cancer
- Hemophilia
- RSV
- Crohn's Disease
- Multiple Sclerosis
- Rheumatoid Arthritis
- Growth Deficiency
- Organ Transplant
- HIV/AIDS

Prescription Drug Coverage During an Emergency or Disaster

This section will apply only if the North Carolina Commissioner of Insurance issues a Bulletin Advisory of:

- A proclamation of state of disaster issued by the Governor or by a resolution of the General Assembly under N.C.G.S. § 166A-6;
- A declaration of major disaster issued by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or
- A state of emergency proclaimed by the Governor under N.C.G.S. § 14-288.15.

In the event of a state of disaster or state of emergency described above, and to the extent required by N.C.G.S. § 58-3-228, the Plan will waive time restrictions on filling or refilling prescriptions requested by a covered person residing in a county that is covered by the disaster declaration or proclamation. This waiver will allow the covered person to obtain a refill on a prescription if there are authorized refills remaining, or to fill a replacement prescription for one that was recently filled, regardless of the previous prescription fill date. The covered person must request the refill or replacement within 29 days after the origination date of the disaster or emergency, subject to extensions of the time period ordered by the North Carolina Commissioner of Insurance. This waiver does not excuse or exempt the covered person from any other terms of the Plan, including but not limited to copayment or Coinsurance requirements. Quantity limits will be consistent with the original prescription and the extra or replacement fill may recognize proportionate dosage use prior to the disaster.

Synchronization

The Plan will provide for synchronization of medication when it is agreed among the covered person, the prescribing Physician, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the covered person for

the management or treatment of the chronic illness. The Plan will provide for synchronization only if the medications:

- are otherwise covered by the Plan;
- are used for treatment and management of chronic conditions, and the medications are subject to refills;
- are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone;
- meet all prior authorization criteria specific to the medications at the time of the synchronization request;
- are of a formulation that can be effectively split over required short-fill periods to achieve synchronization; and
- do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

When applicable to permit synchronization, the Plan will apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy. Any dispensing fee will not be prorated and will be based on an individual prescription filled or refilled.

PREFERRED PROVIDER ORGANIZATIONS (PPO)

This Plan utilizes the MedCost Preferred Provider Organization (PPO) Network.

MedCost provider directories are available online at www.medcost.com.

If you have questions regarding a Hospital, Physician or pharmacy's participation in the MedCost or OptumRx network, you should contact the network.

PPO AND PRESCRIPTION DRUG CONTACT INFORMATION

MedCost at (800) 722-2157, or www.medcost.com

OptumRx Prescription Benefit Services at (888) 543-1369, or www.OptumRx.com

VISION BENEFITS

The Plan will reimburse for vision benefits as provided in the Summary Schedule of Benefits. You may visit the vision care provider of your choice. If your provider does not participate in the Network, you should pay the full fee at the time of service and submit your itemized bill and a completed claim form to the Plan for reimbursement. Benefits are subject to the maximum allowances and frequency limitations listed in the Summary Schedule of Benefits.

Vision claim forms may be downloaded at www.myhealthplanonline.com or requested by calling IMS, toll free, at (800) 426-8739. Please submit your completed claim form and a copy of your paid receipt for vision care to:

NCDS Healthcare Plan
Claims Department

PO Box 1349
Wake Forest, NC 27588

For questions about vision coverage, please call IMS, toll free at (800) 426-8739.

NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may visit www.dol.gov or contact the DOL at 1-866-4-USA-DOL (1-866-487-2365) regarding any complaint. The DOL intends to create a specific complaint portal (as of October 12, 2022, the portal was unavailable.) Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

COVERED CHARGES FOR HEALTH CARE BENEFITS

"Covered Charges" for Health Care Benefits include, but are not limited to, the charges itemized in this section. Benefits are subject to the Co-Pays, Coinsurance and other limitations described in the Summary Schedule of Benefits. Benefits are also subject to the exclusions and limitations set forth below.

1. Charges made by a Hospital for:

   (a) Daily semi-private room and board and general nursing services, or confinement in an intensive care unit. However, the Plan will allow 100% of the room rate in a Hospital with only private rooms.
   (b) Other necessary services and supplies needed while confined.

2. Charges made by an ambulatory surgical center or minor emergency medical clinic for treatment;

3. Charges for professional ambulance service to the nearest facility with the capability of providing adequate Emergency Services and treating Emergency Medical Conditions;

4. Charges made by a Home Health Care Provider for care in accordance with a Home Health Care Plan. Such expenses include:

   (a) Part-time or intermittent nursing care by a registered nurse or a licensed practical nurse, a vocational nurse or public health nurse who is under the direct supervision of a registered nurse;
   (b) Home health aides; and
   (c) Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital or Physician, but only to the extent that they would have been covered under this Plan if the covered person had remained in the Hospital.

   Specifically excluded from coverage under Home Health Care Provider benefit are the following:

   (a) Services and supplies not included in the Home Health Care Plan;
   (b) Services of a person who ordinarily resides in the home of the covered person, or is a close relative to the covered person;
   (c) Services of any social worker; and
   (d) Transportation services.

5. Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility. The patient must be confined within 14 days after his discharge from a Hospital where he was confined for at least 3 successive days. Only charges incurred in connection with convalescence from the Illness or Injury for which the covered person is confined will be eligible for benefits. These expenses include:

   (a) Semi-private room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily room or weekly basis such as

general nursing services. If private room accommodations are used, the daily room and board charge allowed will not exceed the facility's average semi-private rate;

(b) Medical services customarily provided by the convalescent facility, with the exception of private duty or special nursing services and Physicians' fees; and

(c) Prescription drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent period. No other supplies will be covered.

6. Charges made by a hospice for the following services and supplies furnished by the facility for:

   (a) Nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse;

   (b) Medical supplies, including drugs and biologicals and the use of medical appliances;

   (c) Physician's services; and

   (d) Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

7. Charges for the services of a legally qualified Physician for medical care and/or surgical treatments;

8. Charges for drugs requiring the written prescription of a licensed Physician and dispensed by a licensed pharmacist, provided such drugs must be approved by the federal Food and Drug Administration ("FDA") for the treatment of the Illness or Injury for which they are prescribed. Prescription drug benefits will only be provided in accordance with the Prescription Drug Plan provisions, and in no event will coverage be provided for any drug for more than a three-month supply;

9. Charges for pre-natal vitamins and other pre-natal nutritional supplements to the extent allowed under the Prescription Drug Plan provisions, provided such vitamins or supplements are prescribed by a licensed Physician and dispensed by a licensed pharmacist;

10. Charges for prescription drugs approved by the FDA for the treatment of certain types of cancer provided that the drug has been approved by the FDA and has been proven effective and accepted for the treatment of the specific type of cancer for which it has been prescribed in any one of the following: (1) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (2) The Thomson Micromedex DrugDex; (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. Notwithstanding the foregoing, coverage shall not be required for any experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

11. Fees of registered nurses or licensed practical nurses for private duty nursing;

12. Charges for treatment or services rendered by a licensed physical therapist;

13. Charges for restoratory or rehabilitory speech therapy services rendered by a legally qualified Physician or qualified speech therapist that relate to speech loss or impairment due to an Illness or Injury or due to surgery performed on account of an Illness or Injury. Only speech therapy services prescribed by a licensed Physician, rehabilitative in nature, and rendered for the treatment of the diagnosed Illness or Injury will be a covered service.

14. Charges for occupational therapy services rendered by a legally qualified Physician or qualified occupational therapist. Only occupational therapy services prescribed by a licensed Physician, and rendered for the treatment of the diagnosed Illness or Injury will be a covered service (subject to applicable limitations and exclusions in the case of an Occupational Injury).

15. Charges for x-rays, microscopic tests, and laboratory tests;

16. Charges for electrocardiograms (EKG), electroencephalograms (EEG), pneumoencephalogram, basal metabolism tests, or similar well established diagnostic tests generally approved by Physicians;

17. Charges for the cost and administration of an anesthetic;

18. Charges for oxygen and other gases and their administration;

19. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced;

20. Charges for radiation therapy and chemotherapy;

21. Charges arising as a result of a Complication of a covered Employee or Dependent spouse's Pregnancy. "Complication of Pregnancy" includes, but is not limited to, a complication requiring an emergency cesarean section and other complications as determined by the Plan Supervisor.

22. Charges for care of newborn, foster or adopted children, including newborn hearing screening ordered by an attending Physician, subject to applicable limitations contained herein;

23. Charges for circumcision of newborns;

24. Charges for voluntary sterilization of Employees and Dependent spouses;

25. Charges related to or in connection with the diagnosis or treatment of infertility for the Employee and Dependent spouse only. Covered Charges do not include charges related to or in connection with procedures to enhance fertility, including but not limited to: artificial insemination, in-vitro or in vivo fertilization, gamete intrafallopian transfer or other direct attempt to induce pregnancy, or fertility drug therapy;

26. Charges for low-dose screening mammography as follows:

    (a) One or more mammograms a Year for a woman at risk for breast cancer if: (i) there is a personal history of breast cancer, (ii) a biopsy performed on the woman has shown benign breast disease; (iii) the woman's mother, sister, or daughter has or had breast cancer; or (iv) the woman has not given birth prior to age 30;
    (b) One baseline mammogram for any woman age 35 through 39, inclusive;
    (c) One mammogram every other Year for any woman age 40 through 49 inclusive, or more frequently if recommended by Physician; and
    (d) One mammogram every Year for any woman 50 years of age or older.

27. Charges for services and supplies in conjunction with transplant procedures, subject to the following conditions:

    (a) A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the medical necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;
    (b) If the donor is covered under this Plan, eligible medical expenses incurred by the donor will be considered for benefits;
    (c) If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to its eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Lifetime Benefit still available to the recipient;
    (d) If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person;
    (e) The Reasonable and Customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a Covered Charge; and
    (f) Only the following human-to-human organ transplants are covered: kidney transplants, cornea transplants, skin transplants, bone marrow transplants, liver transplants, heart transplants, lung transplants, heart-lung transplants, and pancreas transplants.

28. Charges for treatment of mental infirmities, nervous disorders, alcoholism or chemical dependency. Charges in connection with anorexia, bulimia or autism will be considered under the mental/nervous portion of the Plan;

29. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces, dental splints or orthotics, including corrective shoes;

30. Charges for the rental of a wheelchair, Hospital bed, iron lung or other durable medical equipment (other than hearing aids) required for temporary therapeutic use. If the purchase of this equipment is less expensive than the rental fee, then the purchase price will be considered a Covered Charge;

31. Charges for the initial purchase, fitting and repair of non-cosmetic prosthetic appliances. Covered non-cosmetic prosthetic appliances include only those replacing all or part of an external body part or the eyes or larynx or their function. The type of covered prosthetic appliance will be based on the functional level of the covered Participant or Dependent. Charges for replacement of such non-cosmetic prosthetic appliances are covered only if:

- The prosthetic appliance was installed at least five years prior to its replacement and cannot be made serviceable, or
- The replacement prosthetic appliance is for a covered Participant or Dependent under the age of 17, and the existing prosthetic appliance is no long usable due to the individual's growth.

Replacement for damage due to abuse or misuse by the person will not be covered. For purposes or clarity, coverage does not extend to external or internal power enhancements or power controls for the prosthetic limbs and terminal devices, myoelectric prostheses peripheral nerve stimulators, dental appliances, or prescription lenses (except to the extent therapeutic contact lenses are prescribed as a corneal bandage for a medical condition).

32. Charges for anesthesia, Hospital or other facility charges for dental procedures performed in a Hospital or ambulatory surgical facility for young children and others, provided the treating professional certifies that hospitalization or anesthesia is necessary;

33. Charges for osteoporosis benefits are covered for the following "Qualified Individuals:"

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

34. Charges for prescription contraceptive devices and for Outpatient contraceptive services. Coverage for contraceptive drugs is provided under and subject to the Prescription Drug Plan provisions.

35. Charges incurred for basic diagnostic, therapeutic, or surgical procedures involving any bone or joint of the jaw, face, or head provided the treatment is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint

involved and the condition is caused by congenital deformity, disease, or traumatic Injury.

36. For treatment of conditions of the jaw, authorized therapeutic procedures must include splinting and use of intraoral prosthetic appliances to reposition the bones. Covered Charges will not include orthodontic braces, crowns, dentures, and treatment for periodontal disease, dental root form implants, or root canals.

37. Surgical and non-surgical treatment for temporomandibular joint disorders and bone or joint disorders of the skeletal structure will be covered on the same basis as for any other sickness or Injury.

38. Charges for examinations and laboratory tests for the screening for the early detection of cervical cancer. Examinations and laboratory tests for the screening for the early detection of cervical cancer means conventional PAP smear screening, liquid-based cytology, and human papillomavirus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

39. Charges for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer.

40. Charges for Medically Necessary services used to treat diabetes.

41. Charges for Medically Necessary mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). The decision of whether to discharge an Inpatient following a mastectomy will be made by the treating Physician in consultation with the patient. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse in time between the mastectomy and the reconstruction, subject to the approval of the treating Physician. Coverage for reconstructive breast surgery following a mastectomy is provided regardless of whether the mastectomy was performed while the covered person was covered under this Plan.

42. Charges for Emergency Services to the extent necessary to screen and to prevent a material deterioration of a covered person's condition, within reasonable medical probability, in accordance with U. S. Health Care Financing Administration interpretative guidelines, policies and cases.

43. Charges for covered clinical trials. Covered clinical trials mean phase II, III and IV patient research studies designed to evaluate new treatments, including prescription drugs, that meet ALL of the following requirements: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for the participant or Plan beneficiary compared to available non-Investigational treatment alternatives, (iii) have clinical and preclinical data that shows that trial will likely be more effective for the patient than available non-Investigational alternatives; (iv) involve determinations by treating Physicians, relevant scientific data and opinions of experts in relevant medical specialties; (v) have been approved by centers or cooperative groups

that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and (vi) are conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients.

44. Charges for surveillance tests for women age 25 and older at risk for ovarian cancer. A women is considered at risk of ovarian cancer if she tests positive for hereditary ovarian cancer syndrome, or she has a family history with at least one first-degree relative with ovarian cancer and a second relative (either first or second degree) with breast, ovarian or nonpolyposis colorectal cancer. Surveillance tests mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination.

45. Charges for Standard Preventive Care services.

46. For covered participants and Dependents under the age of 22 years, charges for Medically Necessary hearing aids and related services (including the initial hearing aid evaluation, fitting, and adjustments) and supplies (including ear molds) ordered by a Physician or a licensed audiologist, whether over-the-counter or not, subject to the requirements of this paragraph. Coverage is limited to one new or replacement hearing aid per hearing-impaired ear every 36 months. Coverage for a new replacement hearing aid is available only if alterations to the existing hearing aid cannot adequately meet the needs of the covered individual. Coverage applies to Coverage Periods beginning on and after January 1, 2011.

47. Charges for the diagnosis, evaluation, and treatment of lymphedema. Coverage shall include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse or other health care professional with experience in this treatment.

48. Coverage for diabetes outpatient self-management training and educational services provided by a Physician or a health care professional designated by the Physician; and equipment, supplies, medications, and laboratory procedures used to treat diabetes.

EXCLUSIONS AND LIMITATIONS

No benefits are paid for items described in this section.

- service or supplies not Medically Necessary or required for the covered condition.
- habilitation services – health care services that help a person keep, learn, or improve skills and functioning for daily living. This exclusion does not apply to physical therapy, spinal manipulation/chiropractic, or occupational therapy.
- charges in excess of the prevailing fee for the service or supply.
- orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.
- service or supplies not prescribed by a Physician as required to treat the covered condition.
- over-the-counter drugs.
- vitamins or nutritional supplements, provided that benefits may be paid for nutritional supplements Medically Necessary to sustain life.
- dental care or treatment, except as shown in Covered Charges.
- cosmetic services and surgery except for congenital defects and anomalies of newborns, adopted and foster children and for reconstructive breast surgery following mastectomy as required under the federal Women's Health and Cancer Rights Act.
- services or supplies for the treatment of pregnancy of a Dependent child.
- services or supplies for the treatment of an Occupational Injury, except as specifically provided for covered employees who are eligible for coverage of Occupational Injury as described in the Supplementary Accident Benefit.
- loss or Injury due to war, or act of war (whether declared or undeclared, but not including acts of terrorism).
- loss or Injury due to the person's participation in a riot.
- loss or Injury due to the person's commission of, or attempt to commit, a felony or a crime which would be considered a felony if prosecuted.
- loss to which a contributing cause was the person engaging in an illegal occupation.
- services or supplies provided or paid for by any federal, state or local government (except under Medicaid) unless the person is legally required to pay.
- charges the person is not legally required to pay.
- service or supplies furnished by a person who usually resides in the covered person's home or who is a member of the covered person's family; a family member includes the covered person's spouse and the children, brothers, sisters, and parents of the covered person or his spouse.
- charges incurred in connection with any non-accidental self-inflicted Injury or Illness, unless the self-inflicted Injury is caused by a medical or physical condition.
- immunizations, x-rays or tests not related to Illness or Injury, except as shown in Covered Charges.
- Experimental or Investigative drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of Illness for which the drug was prescribed.
- massage therapy and acupuncture.

- family planning; treatment to enhance fertility; or artificial reproductive procedures including but not limited to: artificial insemination, in-vitro or in vivo fertilization, gamete intrafallopian transfer or other direct attempt to induce pregnancy, or fertility drug therapy.
- the reversal of voluntary sterilization.
- treatment of sexual dysfunction not related to organic disease.
- except for Emergency Services necessary to stabilize and Emergency Medical Condition, complications or side effects from services or treatment excluded by the Plan.
- medical charges for which a participant, his employer, or Workers' Compensation Insurance carrier is liable or responsible according to a final adjudication of the claim or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act. Notwithstanding the foregoing, covered employees of a participating employer shall remain eligible for coverage of Occupational Injury to the extent described in the Supplementary Accident Benefit.
- charges for vision services and supplies except as specifically shown in Covered Charges.
- charges for services and supplies that are part of a course of Inpatient treatment where the covered person fails to complete the course of treatment and such failure is substantially and materially inconsistent with the treating Physician's medical advice. This exclusion will not be applied to a course of Inpatient treatment for substance abuse if it is the first time the covered person has received Inpatient treatment for substance abuse.

COORDINATION OF BENEFITS

Coordination of Benefits means taking other plans into account when paying benefits under this Plan.

A plan is defined as any health coverage that provides benefits or services for medical, dental or vision care on a group basis. "Plan" includes group insurance and self-insured and prepaid plans. It includes government plans and plans required or provided by statute, except Medicaid. "Plan" does not include school accident-type coverages, blanket, franchise, individual, automobile, and homeowner coverages. "Plan" shall be treated separately for each contract or other program benefits or services. "Plan" shall be treated separately for that part of a plan, which reserves the right to coordinate benefits or services of other plans and that part which does not.

Allowable Expenses are those:

- incurred while a person's coverage is in force;
- incurred as extended benefits; and
- does not exceed the prevailing fee for the service or supply; and
- is covered by the applicable Benefit Section; and
- is for the charges the person is legally required to pay.

The difference between the cost of a private Hospital room and that of a semi-private room is not covered as an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary as determined by the Physicians of record. When a plan provides benefits by services, the reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Year means the applicable Coverage Period, or any part of the Coverage Period, during which a person claiming benefits is covered under this Plan.

Coordination of Benefits will apply if, for Allowable Expense incurred during a year, the sum of the items listed below would exceed Allowable Expense.

- The benefits that would be paid under this Plan in the absence of coordination of benefits.
- The benefits that would be paid under all other plans in the absence of provision for coordination in those plans.

When Coordination of Benefits applies, benefits payable under this Plan may be reduced. Benefits will be reduced so that the sum of the benefits paid under this Plan, plus benefits payable under all other plans, does not exceed total Allowable Expense. Benefits "payable" under the other plans include benefits that would be paid had claims been made. When the rules set forth in the provision titled "Rules for Payment When Two or More Plans Contain Coordination of Benefits Provisions" require this Plan to pay its benefits first, coordination will not apply.

The rules for the order of benefit payment are as follows:

- Non-dependent/Dependent – a plan which covers a person other than as a Dependent will pay before a plan which covers that person as a Dependent.
- Dependent Child/Parents not Separated or Divorced – A plan which covers a person as a Dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers that person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If both parents have the same birthday, the plan which has covered the person for the longer period will pay first. If the other plan does not have this provision and this results either in each plan determining its benefits before the other, or in each plan determining its benefits after the other, this provision shall not apply and the rules set forth in the plan which does not have this provision shall determine the order of benefits.
- Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
    - First, the plan which covers the child as a Dependent of the parent with custody of the child;
    - Second, the plan which covers the child as a Dependent of the spouse of the parent with custody; and
    - Finally, the plan which covers the child as a Dependent of the parent without custody of the child.

  However, if specific terms of a court decree states that one of the parents is responsible for the child's health care expense, and the entity obligated to pay or provide the benefits of the plan of that parent has been informed of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Coverage Period during which any benefits are actually paid or provided before the entity has been informed of those terms.
- Dependent Child/Joint Custody. If specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the child's health care expenses, the plan which covers the child shall follow the rules of the order of benefit payment outlined as shown for Dependent Child/ Parents not Separated or Divorced.
- Continuation Coverage. If a person has continuation of coverage under federal or state law and is also covered under another plan, the rules for the order of benefits are as follows:
    - First, the benefits of the plan which covers the person as an employee, member or subscriber (or as that person's dependent);
    - Then, the benefits under the continuation of coverage.

  If the other plan does not have a provision regarding continuation of coverage and if, as a result, the plans do not agree on the order of benefits, then this requirement shall be ignored.
- Laid-off/ Retired. A plan which covers a person on whose expenses a claim is based as a laid-off or retired employee or as the Dependent of such person will pay after any plan covering such person as an employee other than as a laid-off or retired employee or Dependent of such person; and if either plan does not have a provision regarding laid-off or retired employees and, as a result, each plan determines its benefits after the other, then this provision shall not apply.

- Medicare Coverage. The Plan will pay first (and Medicare will be secondary) for:
  - A covered Employee and/or his or her covered Dependent who is age 65 or older, provided the individual is covered through an adopting employer that employs at least 20 employees;
  - A covered Employee and/or his or her covered Dependent who is under age 65 and entitled to Medicare due to permanent and total disability (other than end stage renal disease), provided the individual is covered through an adopting employer that employs at least 100 employees; and
  - The first 30 months of a covered Employee and/or his or her covered Dependent's treatment for end stage renal disease, regardless of the number of employees of the adopting employer through which the individual is covered.

  Medicare will pay first (and this Plan will be secondary) for:
  - A covered Employee and/or his or her covered Dependent who is age 65 or older, provided the individual is covered through an adopting employer that employs fewer than 20 employees;
  - A covered Employee and/or his or her covered Dependent who is under age 65 and entitled to Medicare due to permanent and total disability (other than end stage renal disease), provided the individual is covered through an adopting employer that employs fewer than 100 employees;
  - A covered Employee and/or his or her covered Dependent's treatment for end stage renal disease, following the initial 30 month period described above, regardless of the number of employees of the adopting employer through which the individual is covered;
  - individuals who are retirees; and
  - individuals with Medicare Part B only.

  In all cases, the Plan will administer coordination of benefits with Medicare in accordance with all applicable federal laws and regulations.

When the above rules do not establish an order of payment, the plan which has covered the person for the longer period of time shall pay first.

COORDINATED BENEFITS NOT CHARGES TO BENEFIT LIMIT

If benefits paid under this Plan are reduced because of coordination, each benefit that would otherwise have been paid will be reduced proportionately. Only the amount actually paid will be charged against the applicable benefit limit under the Plan.

BENEFIT CREDIT DUE TO COORDINATION OF BENEFITS

If benefits under this Plan are reduced because of the coordination provisions, the amount of the reduction for a claim will be treated as a benefit credit with respect to such claim. The credit may be used to pay that portion of Allowable Expenses for the following items to the extent otherwise not paid by any plan, insurance policy or prepayment contract:

- daily room, board, general nursing care and supplies furnished by a Hospital;
- charges of a Physician for surgery or medical care;

- services of a registered nurse, but only if the nurse is not a member of the covered person's family;
- licensed ambulance service;
- anesthetics and their administration;
- treatment by a physical therapist;
- x-ray examinations;
- neuroscopic or other laboratory tests made for diagnostic or treatment purposes;
- x-ray, radium, cobalt and radioactive isotopes therapy;
- drugs and medicines that require a prescription and which are dispensed by a licensed pharmacist;
- blood and blood plasma; and
- artificial limbs and eyes.

The above items shall not include dental care expenses, unless the coordination is being applied to dental benefits under the Plan.

The credit may only be used to pay the following:

- That portion of a charge which does not exceed the prevailing fee in the area where the service is rendered;
- That portion of a charge which the covered person is legally required to pay; and
- Expenses incurred during the same year in which the credit accrued.

Total benefits payable for any person for any one year under this Plan shall not exceed the total which would have been payable in the absence of Coordination of Benefits.

RIGHT TO EXCHANGE INFORMATION

The Plan may release to, or obtain from, any other insurance company or organization or person information necessary for coordination of benefits. This will not require the consent of, or notice to, any claimant. A claimant is required to give the Plan Supervisor information necessary for coordination of benefits.

RIGHTS TO MAKE PAYMENT TO OTHER PLANS

Coordination may result in payment made by another plan which should have been made by this Plan. This Plan has the right to pay such other plan all amounts paid by the other plan which would otherwise have been paid by this Plan. The Plan will be discharged from liability to the covered person under this Plan to the extent of such payments.

RIGHTS TO RECEIVE PAYMENTS

Coordination may result in overpayment by this Plan. This Plan has the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments are made.

DEFINITIONS

ALCOHOLIC REHABILITATION FACILITY

The term "Alcoholic Rehabilitation Facility" means a duly licensed institution which is primarily engaged in providing rehabilitative services for alcoholism and/or drug addiction.

ANNIVERSARY DATE

The term "Anniversary Date" means the effective date of the subscriber's participation in the Plan, as specified in the subscriber's Plan Participation Agreement, and each anniversary of such date.

COINSURANCE

The term "Coinsurance" means the percentage of a provider's Reasonable and Customary charge for a covered service that is shared by the Plan and by the covered person.

COPAYMENT

A copayment is the amount of money that is paid each time a particular service is used.

COVERAGE PERIOD

The term "Coverage Period" means the twelve consecutive month period commencing on the subscriber's Anniversary Date.

COVERED CHARGES

The term "Covered Charges" means charges for services, supplies or other items provided to a covered Participant or Dependent that are reimbursable or otherwise covered by the express terms of the Plan. Benefits are subject to applicable Plan exclusions and limitations, and subject to the Plan's general eligibility rules.

DEDUCTIBLE

The term "Deductible" means a specified dollar amount of covered expenses, which must be incurred during a benefit period before any eligible expenses will be considered for purposes of reimbursement. The Family Deductible is based on the covered expenses of all members of the family unit. When the Family Deductible shown in the Schedule of Benefits is satisfied during the Coverage Period, the Deductible for that Coverage Period is satisfied for all members of the family unit.

ELIGIBLE RETIREE

An "Eligible Retiree" is defined as a retired or terminated Plan Participant who satisfies three requirements at the time of his or her retirement or termination with a Participating Employer. First, the Participant must be at least age 55. Second, the Participant must be covered

continuously for at least one year under the Plan immediately before retirement or termination. And third, the Participant must meet the service requirement. The Participant will meet the service requirement if he or she has at least 20 years of continuous service with his or her Participating Employer. The Participant can also meet the continuous service requirement with 20 years of continuous membership with the Plan Sponsor, or with an unbroken combination of such membership and service with his or her Participating Employer.

EMERGENCY MEDICAL CONDITION

The term "Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES

The term "Emergency Services" shall mean health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including pre-Hospital care and ancillary services routinely available to the emergency department

EXPERIMENTAL/INVESTIGATIONAL

The term "Experimental" or "Investigational" means the use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet recognized by the Plan as acceptable medical practice. This term will also apply if the services or supplies required federal or other governmental agency approval and that approval was not granted at the time the services were received. This term shall not include phase II, III and IV clinical trials designed to evaluate new treatments, including prescription drugs, that meet ALL of the following requirements: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for the participant or Plan beneficiary compared to available non-Investigational treatment alternatives, (iii) have clinical and preclinical data that shows that trial will likely be more effective for the patient than available non-Investigational alternatives; (iv) involve determinations by treating Physicians, relevant scientific data and opinions of experts in relevant medical specialties; (v) have been approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and (vi) are conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients.

HOME HEALTH CARE PROVIDER

The term "Home Health Care Provider" means a Hospital, Skilled Nursing Facility, local or state government health department, a community home health agency or other health organization.

A Home Health Care Provider must be duly licensed by the state or certified by the U.S. Health Care Financing Administration as a provider of Home Health Care Services.

HOSPITAL

The term "Hospital" means an institution, that meets all of the following conditions:

- It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
- It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertains to Hospitals;
- It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
- Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by registered nurses;
- It qualifies as a Hospital, a psychiatric Hospital, a tuberculosis Hospital, or Alcoholic Rehabilitation facility for treatment of alcohol or drug addictions and is licensed by the state in which it operates;
- It is a provider of services under Medicare; and
- It is not, other than incidentally a place for rest, a place for the aged, or a nursing home.

ILLNESS

The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a covered person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously that are due to the same or related causes shall be considered one Illness.

INJURY

The term "Injury" means a condition caused by accidental means which results in damage to the covered person's body from an external force. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

INPATIENT

The term "Inpatient" refers to the classification of a covered person when that person is admitted to a Hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the covered person as a result of such treatment.

MEDICALLY NECESSARY

The term "Medically Necessary" means those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, Illness, Injury or disease; and, except as allowed under N.C.G.S. 58-3-255, not for Experimental, Investigational, or cosmetic purposes;
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, Illness, Injury, disease or its symptoms;
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of the covered person, the covered person's family or the provider.

The Plan may compare the cost-effectiveness of alternative services or supplies when determining which among several medically necessary services or supplies will be covered.

MEDICARE

The term "Medicare" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act," and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

MEMBER

A "Member" is an Employee whose coverage has commenced under this Plan.

MENTAL ILLNESS

Mental Illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association.

NETWORK

"Network" means the preferred provider network of Physicians, Hospitals and other providers who contract with MedCost or OptumRx to render health care services to covered persons under plans such as the Plan.

NETWORK PROVIDER

A "Network Provider" or "In-Network Provider" is a Physician, Hospital or other provider who contracts with MedCost or OptumRx to render health care services to covered persons under plans such as this Plan.

OCCUPATIONAL INJURY

The term "Occupational Injury" means any Illness or Injury that is related or attributable to any services performed by the individual for pay or profit.

OPEN ENROLLMENT

The term "Open Enrollment" means a period determined by the Plan Supervisor during which the Plan Supervisor allows participants to enroll themselves and their Dependents for the upcoming Coverage Period.

OUT-OF-POCKET LIMIT

The term "Out-of-Pocket Limit" means the total amount of expenses for covered services that a participant must pay each Coverage Period. Amounts you pay to satisfy Co-pays and Deductibles will count against the Out-of-Pocket Limit. However, charges in excess of the applicable Reasonable and Customary charges, coverage penalties, and amounts not covered by reason of the Plan's coverage limitations do not count against the Out-of-Pocket Limit.

OUTPATIENT

The term "Outpatient" refers to the classification of a covered person when that covered person received medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital if not a registered bed patient at that Hospital, an Outpatient psychiatric facility or an Outpatient Alcohol Rehabilitation Facility.

PARTICIPANT

A "Participant" is a person whose coverage has commenced under this Plan.

PARTICIPATING EMPLOYER

A "Participating Employer" is a group that adopts the Plan for its eligible Employees and their Dependents.

PHYSICIAN

The term "Physician" means a legally licensed medical or dental doctor or surgeon, or other licensed medical practitioner to the extent such practitioner is providing services within the scope of his or her license and practice. A "licensed medical practitioner" includes a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed occupational therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed Physician assistant, a duly licensed marriage and family therapist, or an advance practice registered nurse. A participant or beneficiary of the Plan may choose his or her Physician subject to the utilization review, pre-certification, and In-Network requirements of the Plan. A Physician shall not include the covered person or any close relative of the covered person.

PLAN

The term "Plan" means the North Carolina Dental Society Healthcare Plan.

PLAN PARTICIPATION AGREEMENT

The term "Plan Participation Agreement" means the agreement between a subscriber and the Plan, in the form specified from time to time by the Plan Supervisor, providing for the subscriber's adoption of the Plan and governing the subscriber's contractual relationship with the Plan.

PRIMARY CARE PHYSICIAN

Primary Care Physicians are Family Physicians, General Internists, General Practitioners, Pediatricians, and (for annual female physical exams only) Gynecologists. A participant or Dependent diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition which requires specialized medical care may select as his or her Primary Care Physician a specialist with expertise in treating the disease or condition who will be responsible for and capable of providing and coordinating the participant or Plan beneficiary's primary and specialty care. Participants and Dependents are not required to designate a Primary Care Physician or other primary care provider.

REASONABLE AND CUSTOMARY

The term "Reasonable and Customary" shall mean the usual charge made by the person, group or other entity rendering or furnishing the services, treatment or supplies. In no event shall it mean a charge in excess of the general level of charges made by others rendering or furnishing such services, treatment or supplies, within the area in which the charge is incurred, for Illness or Injury comparable in severity and nature to the Illness or Injury being treated. For purposes hereof, "area," as it would apply to any particular services, treatment or supplies, means a county or such greater area as is necessary to obtain a representative cross section of persons, groups or other entities rendering or furnishing such services, treatment or supplies.

NOTICE: Your actual expenses for covered services may exceed the stated Coinsurance percentage or Co-Pay amount because actual provider charges may not be used to determine Plan and participant/beneficiary payment obligations.

RESIDENTIAL TREATMENT FACILITY

The term "Residential Treatment Facility" means a freestanding institution or facility that meets all of the following conditions:

- It is engaged primarily in providing diagnostic and therapeutic services and facilities for treatment of mental disorders and/or substance abuse on an Inpatient basis at the patient's expense;
- It maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 residential patients;
- Treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by registered nurses;
- It has a full-time psychiatrist or psychologist on staff;

- It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located that pertain to residential treatment of mental disorders and/or substance abuse;
- It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

RETIRED PARTICIPANT

A "Retired Participant" is an Eligible Retiree who maintains individual coverage as a Subscriber. A Retired Participant who continues to practice dentistry on a part-time basis can continue to be covered by the Plan as long as they meet all of the other retiree provisions.

SKILLED NURSING FACILITY

The term "Skilled Nursing Facility" means a duly licensed institution that is primarily engaged in providing skilled nursing care. The institution must be approved as a Skilled Nursing Facility by the Medicare Program, the Joint Commission on Accreditation of Hospitals, or the Plan.

STANDARD PREVENTIVE CARE

The term "Standard Preventive Care" means:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to an individual who is an infant, child or adolescent, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to a woman, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines supported by HRSA.

The determination of whether an item or service qualifies as Standard Preventive Care shall be made in accordance with Section 2713 of the Public Health Service Act and applicable guidance. An item or service will not be considered Standard Preventive Care for purposes of this Plan if the item or service is provided to the individual at a time when the item or service is not specified in a recommendation or guideline used to determine what qualifies as a preventive health service under Section 2713 of the Public Health Service Act. If an item is available for purchase without a prescription, it will not be treated as Standard Preventive Care under the Plan unless it has been prescribed by the individual's Physician.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

www.HealthCare.gov/center/regulations/prevention.html

www.cdc.gov/vaccines//recs/acip/

Except as specifically stated in this Plan Summary, Standard Preventive Care does not include items or services intended to treat an existing illness, injury, or condition (e.g., care described in Appendix F of IRS Notice 2019-45).

SUBSCRIBER

A "Subscriber" is either a Participating Employer, or an individual who enrolls in the Plan's individual coverage.

TRUST

The term "Trust" shall mean the North Carolina Dental Society Healthcare Plan Trust Fund, with principal offices in Cary, North Carolina.

URGENT CARE CENTER

An "Urgent Care Center" is a stand-alone facility operated independently of a Hospital.

MISCELLANEOUS PROVISIONS

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

The Women's Health and Cancer Rights Act of 1998 applies to this Plan. In accordance with the law, any covered person under this Plan entitled to coverage for a mastectomy will also be covered for certain mastectomy related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from the mastectomy (including lymphedema). Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse in time between the mastectomy and the reconstruction, subject to the approval of the treating Physician. Coverage for reconstructive breast surgery following a mastectomy is provided regardless of whether the mastectomy was performed while the covered person was covered under this Plan. You should feel free to contact the Plan Supervisor for more information.

ASSIGNABILITY

Amounts payable under this Plan can be used to make direct payments to Physicians and Hospitals, or the payments may be made to you. You may have to sign an "assignment of benefits" form at the Hospital or Physician's office, or on your claim form to allow the Plan to pay directly to the provider of the service.

CERTAIN PROTECTIONS UNDER STATE LAW

Right to Information on Request

Upon request, the Plan Supervisor will provide you with the following information relating to the Plan and its administration:

- Evidence of coverage, the Plan documents and this Plan Summary;
- An explanation of the Plan's utilization review criteria and treatment protocol for specific conditions, in writing if you so request;
- Upon a denial of a requested treatment, a statement of the reasons for denial and an explanation of the Plan's utilization review criteria or treatment protocol on which the denial is based; and
- An explanation of the Plan's procedures and medically based criteria for determining whether a specified procedure, test or treatment is Experimental.

Right to Choose Non-Network Providers

Covered persons are entitled to receive covered emergency or non-Emergency Services from out-of-network providers at the In-Network benefit level in the event that In-Network providers able to meet the covered person's health needs are not available to the covered person without unreasonable delay. If a qualified In-Network provider is located within a 50 mile radius of the covered person's principal residence, then for purposes of this Plan such provider is deemed able to meet the covered person's health needs without unreasonable delay.

PLAN AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to notice requirements under applicable laws. In case this Plan is terminated and the Trust is unable to fund the cost of benefits incurred to the date of termination, the Trust may assess subscribers to the extent necessary to cover such cost.

FUNDING

Benefits under the Plan are provided from the assets of the Trust, and are not insured by an insurance company. The cost of funding the Trust is shared by the Participating Employers and other subscribers. Participating Employers may require their Employees to pay all or a portion of the cost of coverage.

All contributions are deposited to the Trust. The Trust is managed by a Board of Trustees appointed by the Plan Sponsor. If the assets of the Trust are insufficient to pay the obligations of the Trust, the Trustees may impose a pro rata assessment upon all subscribers who subscribe to the Plan or have subscribed to the Plan during the twenty-four (24) months immediately preceding such assessment. In determining any assessment due, the Trustees may consider the amount of contributions made, the amount of benefit payments received, the types of coverage under the Plan, and any other matters the Trustees deem relevant establishing a fair and equitable assessment for each current or former subscriber.

If the Plan refunds contributions to a Participating Employer that has required its Employees to pay for all or a portion of the cost of coverage, the Participating Employer shall determine in a fair and equitable manner the portion of the refund to which the contributing Employees are entitled and return such amounts to the Employees within 90 days of receiving the refund from the Plan.

NOTICE REGARDING NONPAYMENT OF PREMIUMS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR

RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE REGARDING RE-ISSUANCE OF CHECKS

You must deposit or cash checks you receive from the Plan as soon as possible after receiving them, and in any case within 180 days of the check issue date. The Plan will re-issue a lost check only if you report the lost check within 180 days of the original check issue date. The Plan will impose a $2.50 re-issuance fee for each lost check.

CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM

You should file a claim as soon as you incur health expenses for which this Plan provides benefits, or when you are required to obtain pre-certification of an admission or procedure. Please note that a separate claim form must be submitted for each family member for whom a claim is made. Itemized bills for minor expenses incurred should not be submitted more frequently than once a month.

You will only have 180 days after the date care is provided to file the claim with respect to that care. However, in the case of health care provider facility claims you will have 180 days from the date of discharge from the facility. After the 180-day period, the claim will not be processed unless you demonstrate that you could not have reasonably met the 180-day filing deadline and that you submitted the claim as soon as reasonably possible and in any case other than legal incapacity within one year from the time submission of the claim was otherwise required.

Special COVID-19 Rule: In determining the 180-day period to file a claim under this section, the period from March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by applicable government agencies will be disregarded.

HOW TO FILE A CLAIM

Claims must be filed on claim forms approved by the Plan Supervisor, Claims Administrator, or PPO. You may obtain a claim form from your employer or from the Claims Administrator.

1. You must furnish itemized bills for covered medical and surgical services not reported on the Attending Physician's Statement. Bills must be complete. Each bill, other than for drugs, should be itemized and show: the patient's full name; the Employee's full name and employee benefit number; the date or dates the service was rendered or purchase was made; the nature of the Illness or Injury (i.e., diagnosis); the type of service or supply furnished; and the itemized charges.

2. For Medical Claims, you must mail the completed form to MedCost PPO at the address below.

   MedCost
   PO Box 25307
   Winston-Salem, NC 27114-5307

3. For Hospital admissions, you need only present your ID card to the Hospital. However, pre-certification review is required for non-emergency admissions.

4. For prescription drugs, you need only present your ID card to the OptumRx network pharmacist. For questions relating to prescriptions, call OptumRx Customer Service at 888-543-1369, or visit the OptumRx website at www.OptumRx.com.

5. For Hospital admissions or Outpatient surgery requiring pre-certification review, you or your Physician must call MedCost at (800) 722-2157 to have your admission or Outpatient surgery pre-certified.

REPRESENTATIONS

When you or your Provider files a claim for benefits under the Plan, the filing of the claim constitutes your representation that you are a covered Participant or Dependent under the Plan, that you have received the services or supplies forming the basis of the claim, and that you are responsible for payment for such services or supplies but for the coverage provided by the Plan. The Plan Supervisor, Claims Administrator, or PPO may require you to make additional representations or provide additional information to substantiate your claim, including but not limited to information regarding employment or Dependent status.

UTILIZATION MANAGEMENT DECISIONS AND PROCEDURES

To make sure you have access to high quality, cost-effective health care, the Plan has a Utilization Management (UM) program. The UM program requires that certain health care services you receive be certified by the PPO in order for you to receive benefit coverage. As part of the process, the PPO looks at whether health care services are medically necessary, provided in the proper setting and for a reasonable length of time.

The Plan will honor a certification to cover medical services or supplies under the Plan unless the certification was based on a material misrepresentation about your health condition or you were not eligible for these services under the Plan due to termination of coverage or nonpayment of premiums.

RIGHTS AND RESPONSIBILITIES UNDER THE UM PROGRAM

Your Member Rights

Under the UM program, you have the right to:

- A UM decisions that is timely, meeting applicable state and federal time frames
- The reasons for the Plan's denial of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from the PPO review all denials of service that were based upon medical necessity
- Request a review of denial of benefit coverage through the grievance process. See "Plan Dispute Procedures" below.
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the claimant's behalf with the claimant's written consent. In the event you appoint an authorized representative, references to "you" under the "Utilization Management Decisions and Procedures" section mean "you or your authorized representative." This means that the authorized representative may pursue your rights and shall receive all notices and benefit determinations.

The Plan's Responsibilities

As part of UM decisions, the Plan (through its PPO) will:

- Provide you and your provider with a toll-free telephone number to UM review staff whenever certification of a health care service is needed. See "Claim Filing Instructions" above.
- Limit what the Plan requests from you or your provider to information that is needed to certify the service in question.
- Request all information necessary to make the UM decision, including pertinent clinical information.

- Provide you and your provider prompt notification of the UM decision consistent with the Plan.

In the event the PPO does not receive sufficient information to certify coverage for a health care service within specified time frames, the PPO will notify you in writing that the benefit coverage has been denied. The notice will explain how you may pursue a review of the UM decision.

PROSPECTIVE (PRE-CERTIFICATION) REVIEWS

The Plan requires that certain health care services be reviewed before you receive them. These "pre-certification" reviews are called prospective reviews.

The Plan requires pre-certification for all Outpatient surgery.

The Plan requires pre-certification for all Inpatient Hospital admissions with two exceptions. The two exceptions are Emergency Services and certain maternity admissions as further described below (including newborn nursery care). For maternity admissions, your doctor is not required to obtain pre-certification from the Plan for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your doctor must request pre-certification for coverage for additional days, which will be allowed by the Plan if Medically Necessary. Although pre-certification is not required for Emergency admissions, please notify the Plan of your Inpatient admission as soon as reasonably possible.

If you receive care from an In-Network Provider, certification will be arranged for you through the PPO. You should check with your In-Network Provider to make sure that certification has been obtained. Your In-Network Provider must use the Plan's Network Hospital where he/she practices, unless that Hospital cannot provide the services needed.

If you want to receive care from an out-of-network Provider, you or your doctor must request certification from the Plan. This is done by calling the PPO at the number given in "Claim Filing Instructions" above. If the requested coverage is denied, you have the right to appeal. See "Plan Dispute Procedures" for additional information. Certain services may not be covered out-of-network. See the above sections describing the Plan's Health Care Benefits.

If the terms of this Plan require pre-certification for a Hospital admission or Outpatient treatment and you fail to obtain the required certification, the benefits otherwise payable will be reduced by $250.

The PPO will make a decision on your request within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your provider within two business days after the PPO receives all necessary information but no later than 15 days from the date the PPO received the request.

If your request is incomplete, the PPO will notify you and your provider within 5 days of how to properly complete your request. The PPO may extend this deadline to 15 days if additional time is needed. The PPO will notify you and your provider before the end of the initial 15-day period of the information needed and the date by which the PPO expects to make a decision. You will have 45 days to provide the requested information. Once the PPO receives the requested

information, or at the end of the 45 days, whichever is earlier, the PPO will make a decision within two business days. If the PPO does not certify benefit coverage of a health care service, the PPO will notify you and the provider by written or electronic confirmation. The PPO will communicate prospective review decisions to you and your provider within one business day after the PPO makes a decision.

Noncertification determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness, are made by the PPO's medical director. Coverage for services which are subject to the Exclusions, Conditions, and Limitations outlined in the covered person's certificate of coverage may be denied by the PPO's review staff without review of the PPO medical director.

EXPEDITED PROSPECTIVE REVIEW

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment.

The PPO will notify you and your provider of its decision as soon as possible, taking into account the medical circumstances. The PPO will notify you and your provider of its decision within 2 business days after the PPO receives all necessary information but no later than 72 hours after receiving the request.

If the PPO needs additional information to process your expedited review, the PPO will notify you and your provider of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information.

As soon as the PPO receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, the PPO will make a decision on your request within a reasonable time but no later than 48 hours.

An expedited review may be requested by calling the PPO's number given in "Claim Filing Instructions."

CONCURRENT REVIEWS

The PPO will also review health care services provided during a Hospital admission at the time you receive them. These types of reviews are called Inpatient reviews or "concurrent reviews."

The PPO will communicate concurrent review decisions to the Hospital or other provider within one business day after the PPO makes a decision. If the PPO does not certify benefit coverage of a health care service or continued stay in the Hospital, the PPO will notify you, your Hospital's or other provider's UM department and your provider. Written confirmation of the decision will be sent to your home by U.S. Mail.

For concurrent reviews, the Plan will remain responsible for covered services you are receiving until you or your representatives have been notified of the denial of benefit coverage.

EXPEDITED CONCURRENT REVIEW

You have a right to an expedited review when the regular time frames for a concurrent review decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment.

If you request an extension of treatment that the PPO has already approved at least 24 hours before current approved treatment ends, the PPO will notify you and your provider of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

RETROSPECTIVE REVIEW

The PPO also may review the coverage of health care services after you receive them (called "retrospective reviews"). Retrospective review may include a review to determine if services received in an Emergency setting qualify as Emergency Services. When conducting a retrospective review, the PPO will make its determination within 30 days from the date the PPO has received all necessary information relating to the services under review. When the decision is to deny benefit coverage, the PPO will notify you and your provider in writing within five business days of the decision.

All decisions will be based on Medical Necessity and whether the charge was a Covered Charge under this Plan.

Services that were certified in advance by the PPO will not be subject to denial for Medical Necessity once the claim is received, unless the certification was based on material misrepresentation about your health condition or you were not eligible for these services under the Plan due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for Medical Necessity or for a benefit limitation or exclusion.

FURTHER REVIEW OF UTILIZATION MANAGEMENT DECISIONS

If certification for benefit coverage for health care services is denied, you have the right to request that the Plan review the decision through the grievance process. Refer to "Plan Dispute Procedures" for additional information.

ADVERSE BENEFIT DETERMINATIONS

For purposes of this Plan, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, even if it is based on a determination of a claimant's eligibility to participate in the Plan, including 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, or on

account of a Plan provision or exclusion relating to medical necessity, or Experimental or Investigational treatments. The term "adverse benefit determination" also includes a rescission of coverage (within the meaning of Section 2712 of the Public Health Service Act).

A noncertification determination is a utilization management determination by the Plan that an admission, availability of care, continued stay, or other health care service does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The Claims Administrator must provide a claimant with a written or electronic notice of any adverse benefit determination. Electronic notification must comply with applicable standards under ERISA regulations. In either case, the notification must set forth:

- the specific reasons for the adverse determination;
- reference to specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the material or information is necessary;
- a description of the Plan's claims review or grievance procedures and the time limits applicable to such procedures (including, a statement of the claimant's right—to the extent ERISA applies to the claimant—to bring a civil action under ERISA Section 502(a) following an adverse determination on review);
- a description of the expedited review process if the claim involves urgent care;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse 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 in making the determination and that a copy will be provided free of charge upon request;
- if the decision is a "noncertification determination," a statement informing the claimant that if the claimant has a medical condition where the time frame for completion of an expedited review of a grievance would reasonably be expected to seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function, the claimant may file a request for an expedited external review with the Commissioner of Insurance at the same time the claimant files a request for expedited review of the Grievance, but that the Commissioner will determine whether the claimant shall be required to complete the expedited review of the Grievance before conducting the expedited external review;
- any other information that is required by applicable regulations under Section 503 of ERISA or Section 2719 of the Public Health Service Act, or under applicable guidance.

Notwithstanding the foregoing, in the case of an adverse benefit determination involving urgent care, the required information may be provided orally within the applicable time frame prescribed above, provided that a written or electronic notification is furnished not later than three days after the oral notification.

PLAN DISPUTE PROCEDURES

In addition to the UM program, the Plan offers a grievance procedure for covered persons. A covered person may file a grievance if the covered person is dissatisfied with an adverse benefit

determination or any decision (including an appeal of a noncertification decision), policies or actions related to the availability, delivery or quality of health care services. If you have a grievance, you have the right to request that the Claims Administrator or the Plan Supervisor review the decision through the grievance process. The grievance process is voluntary and may be requested by the covered person or an authorized representative acting on the person's behalf with the person's written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you and your representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). For each step in this process, there are specified time frames for filing a grievance and for notifying you or your provider of the decision.

STEPS TO FOLLOW IN THE GRIEVANCE PROCESS

Grievance Review

The review should be requested in writing, within 180 days of a denial of benefit coverage. The Plan does not have a prescribed form for requesting a grievance review, but you should make sure your request includes:

- The covered person's ID number;
- The covered person's name;
- Patient's name;
- The nature of the grievance; and
- Any other information that may be helpful for the review.

There are two types of grievances. Most grievances should be directed to the Claims Administrator. However, if the grievance relates to a determination that the claimant is not an eligible member or Dependent under the Plan (an "eligibility grievance"), you should direct the eligibility grievance to the Plan Supervisor for review. If you are not sure, you may direct your grievance to the Claims Administrator and the Claims Administrator will refer it to the Plan Supervisor if it is an eligibility grievance.

In the following description of the grievance procedures, the term "Administrator" shall mean the Plan Supervisor in the case of an eligibility grievance, and the Claims Administrator in all other grievances.

Within three business days after receipt of a review request, the Administrator will provide you with the name, address and phone number of the grievance coordinator. The Administrator will also give you instructions on how to submit written materials. For grievances concerning the quality of health care, an acknowledgement will be sent by the Administrator within 5 business days.

The Administrator shall give the claimant the opportunity to review the claim file, to submit written comments, documents, records, and other information relating to the claim, and to present evidence and testimony as part of the grievance process. The Administrator shall give the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim. Documents, records, and other

information are considered relevant for purposes of the Plan's Dispute Procedures if they were relied upon in making the benefit determination, if they were submitted, considered or generated in the course of making the determination, if they demonstrate compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the Plan and that Plan provisions have been applied consistently, or if they constitute a statement of Plan policy or guidance with respect to the denied treatment option or benefit for the claimant's diagnosis.

When a grievance is received by the Administrator, the Administrator will proceed with a formal review of the grievance and render a decision. The Administrator shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such materials were submitted or considered in the initial benefit determination. The Administrator shall not afford any deference to the initial adverse benefit determination.

The individual who reviews the grievance on behalf of the Administrator may not be an individual who made the initial adverse benefit determination, or a subordinate of that individual. If the adverse benefit determination was based in whole or in part on a medical judgment, the Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulted professional may not be an individual consulted in connection with the adverse benefit determination, nor a subordinate of such individual.

The Administrator shall identify to the claimant any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, even if the advice was not relied upon.

You are not allowed to attend a grievance review. The Administrator will notify you in clear written terms of the decision, within a reasonable time but no later than 30 days after receipt of your grievance filing, unless your claim involves urgent care, in which case the Administrator will notify you as soon as possible, but not later than 72 hours after receipt of the your grievance filing.

After receiving notice of the Administrator's decision, you may then request all information that was relevant to the review.

Manner and Content of Notice of Benefit Determination Following Grievance Review

The Administrator must provide you with a written or electronic notice of its benefit determination upon review of the grievance. Electronic notification must comply with applicable standards under ERISA regulations. If the benefit determination is adverse to you, the notification must set forth:

- the specific reasons for the adverse determination;
- reference to specific Plan provisions on which the determination is based;

- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits;
- a description of any voluntary review or grievance procedures offered by the Plan and the claimant's right to obtain information about those procedures;
- a statement of the claimant's right—to the extent ERISA applies to the claimant—to bring a civil action under ERISA Section 502(a) following an adverse determination on review;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notification shall include 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 in making the determination and that a copy will be provided free of charge upon request.
- if the adverse determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, the notification shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- in the case of a noncertification determination, the notification must inform the claimant that if the claimant has a medical condition which qualifies as an urgent care claim, the claimant may file a request for an expedited external review with the Commissioner of Insurance.
- if the benefit determination relates to a pre-certification review and the decision concerns admission, availability of care, continue stay, or health care service for which the claimant received Emergency Services but has not been discharged from a facility, the notification must inform the claimant that the claimant may file a request for an expedited external review with the Commissioner of Insurance.
- any other information that is required by applicable regulations under Section 503 of ERISA or Section 2719 of the Public Health Service Act, or under applicable guidance.
- the following statement:

  "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and the North Carolina Department of Insurance."

Second Level Grievance Review

If ERISA applies to the claimant, then the first level grievance review is the only level that you must complete before you can pursue your grievance in an action in federal court.

If you are dissatisfied with the first level grievance decision, you have the right to a second level grievance review. Second level grievances are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. The request for a second level grievance review must be made in writing within 90 days of the decision rendered in the first level grievance review.

Within 10 business days after receipt of the second level grievance review request, the Administrator will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the Administrator's grievance coordinator for your case
- A statement of your rights, including the right to:
  - Request and receive from the Administrator all relevant information that applies to your case
  - Attend the second level grievance review meeting
  - Present your case to the review panel
  - Submit supporting material before and at the review meeting
  - Ask questions of any member of the review panel
  - Be assisted or represented by a person of your choosing, including a family member, employer representative, or attorney

The second level review panel will meet to consider the matter within 45 calendar days after the Administrator's receipt of the request for a second level grievance review. The review panel will be selected by the Administrator. The panel will not include persons who were previously involved in the matter giving rise to the grievance, employees of the Plan, or any persons who have a financial interest in the outcome of the review. All persons reviewing a second-level grievance involving a noncertification or a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. However, if the Administrator used a clinical peer on the underlying appeal of a noncertification or the first-level grievance review panel, the Administrator may use one of its own employees on the second-level review panel instead of a clinical peer.

The second level review meeting may be held by teleconference or video conference. You will be given notice of this meeting at least 15 days before the meeting date but are not required to attend. A written decision will be provided to you within seven business days after the panel completes its review meeting. The decision will include:

- The professional qualifications and licensure of the members of the review panel.
- A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
- The review panel's recommendation to the Plan and the rationale behind that recommendation.
- A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
- In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
- The rationale for the Plan's decision if it differs from the review panel's recommendation.
- A statement that the decision is the Plan's final determination in the matter. In cases where the review concerned a noncertification and the Plan's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
- Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

- Notice of the availability of assistance from the Health Insurance Smart NC program, including the telephone number and address of the Program.

Special COVID-19 Rule

In determining the 180-day deadline in which you may request an appeal of a denial of benefit coverage, the period from March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by applicable government agencies, will be disregarded.

EXPEDITED REVIEW

You have the right to a more rapid or expedited review of a first or second level grievance involving a denial of a claim involving urgent care. A claim involving urgent care is any claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) would reasonably appear to seriously jeopardize you or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your provider, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling the Administrator at the number given in "Claim Filing Instructions" The Administrator's expedited review will take place in consultation with a medical doctor. All of the same conditions for the first level or second level grievance review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. Provided that you or your provider has provided sufficient information for the Administrator to determine whether or to what extent benefits are covered, the Administrator will communicate the decision by phone to you and your provider as soon as possible, taking into account the medical circumstances, but no later than 24 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the Plan will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

HEALTH INSURANCE SMART NC PROGRAM

North Carolina has established a managed care advocacy program to assist subscribers, participants and providers in dealing with managed care issues. Services provided by the Health Insurance Smart NC program are available through the North Carolina Department of Insurance. Subscribers and participants may call the Health Insurance Smart NC program toll-free at (855) 408-1212. The mailing address is: Health Insurance Smart NC, North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201.

EXTERNAL REVIEW

North Carolina law provides for review of noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. The Administrator will notify you of your right to request an external review each time you receive:

- a noncertification decision, or
- an appeal decision upholding a noncertification decision; or
- a second level grievance decision upholding a noncertification decision.

In order for your request to be eligible for external review, the NCDOI must determine the following:

- that your request is about a medical necessity determination that resulted in a noncertification determination;
- that you had coverage under the Plan in effect when the noncertification determination was issued;
- that the service for which the noncertification decision was issued appears to be a covered service under the Plan; and
- that you have exhausted the Plan's internal review process as described below.

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

For a standard external review, you will have exhausted the internal grievance review process if you have:

- completed the Plan's first and second level grievance review process and received a written second level determination from the Plan with respect to your grievance, or
- filed a second level grievance and except to the extent that you have requested or agreed to a delay, you have not received the Plan's written decision on appeal within 60 days of the date you submitted the request, or
- received written notification that the Plan has agreed to waive the requirement to exhaust the internal appeal process.

Standard Review. If the request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have already received the services in question), you will not be eligible to request a standard review until you have completed the Plan's internal review procedures and have received a final written determination from the Administrator.

If you wish to request a standard external review, you (or your representative) must file your request with the NCDOI within 120 days of receiving the Plan's written notice of final determination that the services in question are not approved. When processing your request for

external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the Plan's written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include the following: (i) the name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that the Plan has provided to the NCDOI; (iii) notice that the Plan will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and (iv) a notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If you choose to provide any additional information to the IRO, you must also provide that same information to the Plan at the same time and by the same means of communication (e.g., you must fax the information to the Plan if you faxed it to the IRO). When faxing information to the Plan, send it to 1-919-678-1348. If you choose to mail your information, send it to North Carolina Services for Dentistry, Inc., 1600 Evans Road, Cary, NC 27513.

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

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

Expedited Review. An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal first or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written request to the NCDOI for an expedited external review, after you:

- receive a noncertification decision from the Plan AND file a request with the Plan for an expedited first level grievance review;

- receive a first level grievance decision upholding a noncertification decision and file a request with the Plan for an expedited second level grievance review; or
- receive a second level grievance review decision upholding the original noncertification.

You may also request an expedited external review if you receive an adverse first or second level grievance review decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the Inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if you have exhausted the Plan's internal appeal process; or (2) require the completion of the Plan's internal appeal process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision within 3 days of the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, the Plan will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by the Plan at the time the Plan receives notice of the IRO's decision to reverse the noncertification, the Plan will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on the Plan and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification for which you have already received an external review decision.

For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Fax: (919) 807-6865

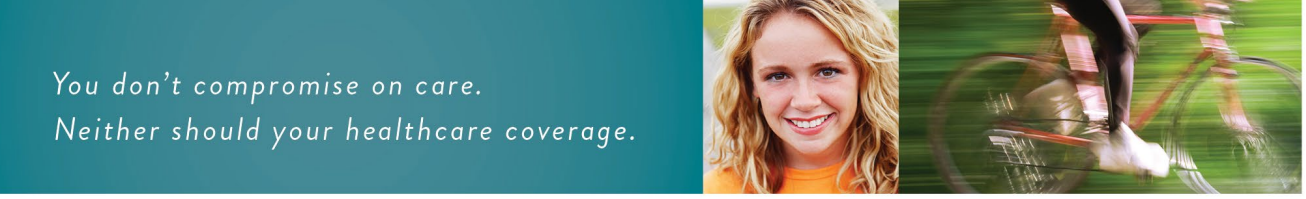
(In person)
North Carolina Department of Insurance
Health Insurance Smart NC
325 N. Salisbury St.
Raleigh, NC 27603
Telephone (toll-free): 1-855-408-1212
Telephone: (919) 807-6860

https://www.nc.gov/services/health-insurance-smart-nc-program for External Review information and Request Form.

The Healthcare Review Program is available to provide Consumer Counseling on utilization review and internal appeals and grievance issues.

DEPARTMENT OF INSURANCE ASSISTANCE

The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at 1201 Mail Service Center, Raleigh, NC 27699-1201, or by telephone at 1-800-546-5664.



North Carolina Dental Society Healthcare Plan

P.O. Box 1349
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FAX (919) 562-0025

NORTH CAROLINA DENTAL
SOCIETY HEALTHCARE PLAN