Certificate of Coverage

FIRSTCAROLINACARE INSURANCE COMPANY, INC.

2008 CERTIFICATE OF COVERAGE

Health Maintenance Organization Plan

THIS CERTIFICATE OF COVERAGE INCLUDES A PRE-EXISTING CONDITION EXCLUSION

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

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

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Special North Carolina Notice

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

WELCOME

Welcome to FirstCarolinaCare Insurance Company, Inc. (also called FirstCarolinaCare Insurance Company or FCCI). This page has some valuable tips on how get the most from your benefits under the FCCI Health Maintenance Organization Plan. You may choose from a large network of Participating Providers. You also have access to Specialists without a referral.

HELPFUL TIPS ON GETTING THE MOST FROM YOUR BENEFITS

- Read all information provided, especially your Certificate of Coverage and your Schedule of Medical Benefits. Become familiar with services excluded from coverage (see the Exclusions section).

- At the beginning of your Certificate of Coverage is a list of definitions of words used throughout. It is very helpful to become familiar with these words and their definitions.

- Identification Cards are provided to all Members. The FCCI ID Card must be shown when obtaining health care services.

- The list of Participating Providers changes from time to time. You should always call in advance to make sure that the Provider is a Participating Provider. The list of Participating Providers is available on line at www.firstcarolinacare.com. The FCCI Provider directory in booklet form is available by calling Member Services at the toll free number provided on the ID Card and under Important Telephone Numbers in this Certificate of Coverage.

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

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- Services received from a Non-Participating Provider will not be Covered Services unless the services are Emergency Services or are not available from a Participating Provider without unreasonable delay.

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

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

- Precertification is required on certain Covered Services, as described in this Certificate under the Medical Management section of this Certificate of Coverage. It is the Member's responsibility to make sure required Precertifications are obtained. Member Services can answer any questions on Precertification requirements.

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

IMPORTANT INFORMATION ABOUT HEALTH CARE FRAUD PREVENTION

It is estimated that health care fraud costs Americans billions of dollars annually. What can be done to help prevent health fraud? The most important thing is for Members to look carefully at the Explanation of Benefits forms sent to Subscribers by FCCI that explain how claims for services are paid. Check to make sure that the services listed accurately state the services received. If there is a service listed that the Member does not believe he/she received, the Provider should be contacted to see if there was a billing error. If the issue is not resolved or if it is suspected that fraud has occurred, call FCCI at 1-910-715-8100.

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

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IMPORTANT TELEPHONE NUMBERS

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

Pharmacy Benefits Manager
For questions related to Prescription Drug benefits, call: **800-788-2949 (toll free)**

Behavioral Services and Chemical Dependency
To request Precertification of Behavioral or Chemical Dependency services call: **800-574-8556 (toll free)**

Precertification
To request Precertification or for questions related to Precertification, call: **800-574-8556 (toll free)**

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

FCCI Main Office
For any additional questions or information, call: **800-574-8556 (toll free) or 910-715-8100**

NC Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
(800) 546-6554 (for residents of NC only)
(919) 733-2004 (for persons outside of NC)

Managed Care Patient Assistance Program - North Carolina Attorney General's Office
Consumers who wish to receive information, advice and assistance may contact the Program by:

- email at MCPA@ncdoj.com;

- by telephone at 1-866-867-MCPA (6272), (toll-free for residents of North Carolina only) or 919-733-MCPA (6272) (for persons outside of North Carolina); or

- by writing to:

  Managed Care Patient Assistance
  Attorney General's Office
  9001 Mail Service Center, Raleigh, NC 27699-9001

  Physical Address: 114 West Edenton Street
  Raleigh, NC 27603

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TABLE OF CONTENTS

DEFINITIONS ---- 1

ELIGIBILITY AND ENROLLMENT ---- 11

Subscriber Enrollment ---- 11

Dependent Enrollment ---- 12

Qualified Medical Child Support Orders ---- 12

Pre-Existing Condition Exclusion For Late Enrollees ---- 13

Special Enrollment ---- 13

Enrollment Changes ---- 14

When Enrollment Ends ---- 15

Certificates Of Coverage ---- 16

GENERAL INFORMATION ABOUT BENEFITS ---- 16

Member Cost Sharing ---- 16

About Selecting Providers ---- 17

Continuity of Service ---- 17

COVERED SERVICES ---- 19

Wellness and Preventive Services ---- 19

Coverage for Certain Treatment of Diabetes ---- 20

Physician Services and Office Visits ---- 20

Emergency Services ---- 20

Hospital Stay other than Maternity Care ---- 21

Outpatient Services and Surgery ---- 21

Skilled Nursing Facility Services ---- 21

Home Health Care ---- 22

Short-term Outpatient Rehabilitation Service ---- 22

Imaging and Laboratory Procedures ---- 22

Reproduction Related Services ---- 22

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Behavioral Health Services ---------- 23

Chemical Dependency Services ---------- 23

Diagnostic Services for Developmental Delays or Learning Disabilities ---------- 24

Treatment of the Bones or Joints of the Jaw, Face or Head ---------- 24

Treatment of Teeth and Special Dental Services ---------- 24

Durable Medical Equipment ---------- 24

Prosthetics/Orthotics ---------- 25

Ambulance Service ---------- 25

Prescription Drugs ---------- 25

Covered Clinical Trials ---------- 25

Reconstructive Breast Surgery ---------- 26

Gastric Surgery ---------- 27

Organ and Tissue Transplants ---------- 27

Reconstructive Surgery (not including Reconstructive Breast Surgery) ---------- 27

Other Services ---------- 28

EXCLUSIONS AND LIMITATIONS ---------- 28

MEDICAL MANAGEMENT ---------- 32

Procedures For Precertification ---------- 32

Procedures For Certification ---------- 33

Expedited Precertifications And Certifications ---------- 33

HOW TO CLAIM BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PARTICIPATING PROVIDERS ---------- 34

COORDINATION OF BENEFITS ---------- 35

Order of Payment ---------- 35

Facility Of Payment ---------- 36

Right Of Recovery ---------- 36

Coordination With Medicare ---------- 36

CONTINUATION OF COVERAGE AND CONVERSION COVERAGE ---------- 36

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Generally ---------- 36

Continuation Coverage ---------- 37

Conversion Coverage ---------- 40

MEMBER RIGHTS AND RESPONSIBILITIES ---------- 41

Member Rights ---------- 41

Member Responsibilities ---------- 41

Advance Directives ---------- 42

COMPLAINTS, APPEALS AND GRIEVANCE PROCEDURES ---------- 43

Quality of Care Complaints ---------- 43

Standard Appeals ---------- 43

Expedited Appeals ---------- 44

Grievance Procedures ---------- 45

External Review ---------- 46

Standard External Review ---------- 47

Expedited External Review ---------- 48

Additional Information ---------- 49

GENERAL PROVISIONS ---------- 50

Notices ---------- 50

Independent Contractor Relationship ---------- 50

Warranties ---------- 50

Waiver Of Certificate Provision ---------- 50

Unenforceability Or Invalidity Of Any Provision ---------- 50

Amendment And Termination ---------- 50

Discretionary Authority ---------- 51

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FIRSTCAROLINACARE HEALTH MAINTENANCE ORGANIZATION (“HMO”) PLAN

This HMO Plan was selected by the Employer, which signed a Master Employer Agreement with FCCI.

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

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

DEFINITIONS

The following definitions apply to the terms used in this Certificate. These definitions do not imply coverage under this Certificate.

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

Advance Directives - the directions a person may write to tell Providers how the person wants to be treated if the person becomes very ill and not able to talk or think clearly. These directions contain the person's wishes about accepting or refusing certain care or treatment.

Appeal - a request for review of a decision to deny Certification or Precertification of a health service.

Behavioral Health Services - services to treat emotional, mental or nervous conditions (other than Chemical Dependency).

Calendar Year - a period of 12 months that starts on January 1 and ends on December 31.

Certificate of Creditable Coverage - a written certification of:

- The period of Creditable Coverage of the Member under this plan, and any coverage under COBRA related to this plan; and
- Any waiting period and affiliation period, if applicable, imposed with respect to the Member for any coverage under this plan.

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

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Chemical Dependency - use of alcohol or other drugs that causes physical addiction, and/or behavioral and social problems.

Chemical Dependency Treatment Provider - a Provider of care and treatment for Chemical Dependency.

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

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

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

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

The following conditions are not Complications of Pregnancy:

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

Continuation Coverage - group health coverage that may be continued under federal or state law under specified terms and conditions when certain qualifying events occur.

Conversion Coverage - a form of individual coverage that may be issued without evidence of insurability to persons who lose group coverage.

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

Covered Clinical Trials - subject to additional requirements set forth in the "Covered Services" section relating to Covered Clinical Trials and N.C. Gen. Stat. § 58-3-255, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Cover or Covered - eligible for benefits under this Certificate.

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

Creditable Coverage - health coverage that may reduce or eliminate a Pre-Existing Condition Exclusion period, including:

- A self-funded employer group health plan under the Employee Retirement Security Act of 1974 ("ERISA");
- Group or individual health insurance coverage;
- Medicare or Medicaid;
- Coverage under General Military Law;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A public health plan (as defined in federal regulations);
- A Peace Corps health benefit plan; or
- A State children's health plan.

Coverage under a short-term limited duration health insurance policy will be included as Creditable Coverage if the period of short-term coverage does not exceed 12 months.

Creditable Coverage does not include supplemental benefits.

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

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Deductible - an amount of money paid for Covered Services before FCCI starts paying benefits.

Dental Services - professional services for the diagnosis and treatment of disease or defects, or accidental Injury to the teeth, gums, jaws and associated structures, and the alveolar processes. Dental Services include examinations, and consultations, oral surgery and hospitalization for dental related care.

Disenroll(ment) - the process of termination of coverage with FCCI.

Eligibility Date - the date when a person meets all requirements for coverage and may Enroll as a Member with FCCI.

Eligible Dependent - a person who:

- is the Subscriber's spouse living in the same residence as the Subscriber and not legally separated from the Subscriber;
- is not on active duty in the armed services;
- is not eligible for coverage under another employer-sponsored health plan as an employee (does not apply to Subscriber spouses);
- is unmarried, under age 26 and is either:
  - ° a stepchild of the Subscriber so long as the stepchild's natural or adoptive parent is not legally separated from the Subscriber;
  - ° a Foster Child, an adopted child or a child placed for adoption (that is, for whom the Subscriber has assumed a legal obligation for total or partial support);
  - ° a natural or adopted child of the Subscriber, regardless of whether or not such child is living in the same residence with the Subscriber; or
- is unmarried and 26 years old or older and:
  - ° is not capable of self-support as a result of mental retardation or a physical handicap, subject to the following conditions:
    - + the child must have become incapable prior to his or her 26th birthday and must be Enrolled with FCCI when he or she reaches age 26 and be chiefly dependent on the Subscriber for support;
    - + the child must stay in the condition described above; or
- is the subject of a Qualified Medical Child Support Order.

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Eligible Employee - means, with respect to a Small Employer, an employee who works for a Small Employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or partnership, or an independent contractor, if included as an employee under a health care plan of a Small Employer, but does not include employees who work on a part-time, temporary, or substitute basis. It does not include employees who are on leave or absent from work for reasons other than disability or illness. With respect to a large employer (51 employees or more), it means those employees designated by the employer as eligible for health benefits.

Emergency Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

Enrolled or Enrollment - the process of becoming a Member of FCCI and becoming eligible for benefits under a Certificate of Coverage.

Enrollment Date - the date when a person is Enrolled as an FCCI Member. If the individual is subject to a Pre-Existing Condition Exclusion, the Enrollment Date is the date of Enrollment, or the first day of the Waiting Period, whichever is earlier.

Enrollment Form - a form used by FCCI to enroll Members.

ERISA - the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1133, 1135, as amended.

Experimental/Investigational - Except as described in N.C. Gen. Stat. 58-3-200(b) for Covered Clinical Trials, treatments, procedures, devices, drugs, or medicines for which one or more of the following is true, as determined by FCCI:

- Reliable evidence shows that the treatment, procedure, device, drug or medicine is:

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   - the subject of ongoing clinical trials; or

   - under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness as compared with the standard means of treatment or diagnosis.

- Reliable evidence shows that experts agree that further studies or clinical trials are needed on the treatment, procedure, device, drug, or medicine. These studies would test the safety and effectiveness of the treatment compared to other accepted treatment.

- Is not approved for sale by the U.S. Food and Drug Administration (FDA) or is not approved by the FDA for use other than that defined under the terms of the FDA approval. A drug will not be considered experimental or investigational if it is approved by the FDA for treatment of a type of cancer and the Physician prescribes the drug for the treatment of another type of cancer so long as the drug has been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following books:

   - AMA Drug Evaluation;

   - AHA Formulary Service Drug Information; or

   - The U.S. Pharmacopeia Drug Information.

For purposes of this definition "reliable evidence" means:

- published reports and articles in medical and scientific literature;

- the written protocol(s) used by the treating facility or the protocol(s) of another facility studying the same treatment, procedure, device, drug, or medicine; or

- the written informed consent used by the treating facility or by another facility studying the same treatment, procedure, device, drug, or medicine.

Foster Child - a minor over whom: (i) a guardian has been appointed by the clerk of superior court of any county in North Carolina; and (ii) primary or sole custody has been assigned to the Subscriber by order of a court.

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

- FCCI's decisions, policies or actions related to availability, delivery or quality of health care services. A written complaint submitted by a Member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a Grievance if the exclusion of the specific service requested is clearly stated in this Certificate;

- Claims payment or handling, or reimbursement for services;

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- The contractual relationship between a Member and FCCI; or
- The outcome of an appeal of a Noncertification.

Health Service Facility - any place that provides health care treatment that is licensed by the state and includes facilities such as:

- Hospitals;
- Nursing homes;
- Psychiatric clinics;
- Alcohol and drug abuse treatment centers;
- Psychiatric facilities;
- Rehabilitation facilities;
- Long-term care facilities;
- Kidney disease treatment centers;
- Intermediate-care facilities for behavioral services;
- Home Health Care facilities (including services in the patient's homes, when applicable); and
- Ambulatory surgical facilities.

Home Health Care - services provided by a Provider licensed to render home health services.

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

Hospital Stay - a period of time when a patient stays as a bed patient in a Hospital and is charged for room and board.

Identification Card (ID Card)- a card given to a Member to show he/she is Enrolled with FCCI.

Injury - an accident that causes bodily harm.

Late Enrollee - a person who enrolls in FCCI at a time other than during:

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- the Open Enrollment Period or, if a new hire, within 31 days of the Eligibility Date; or

- a Special Enrollment Period, when applicable.

Master Employer Agreement - an agreement between the Employer and FCCI under which Eligible Employees and Eligible Dependents receive benefits for the health care services and supplies described in a Certificate of Coverage.

Maximum Allowable Payment (MAP) - the highest amount that will be paid for Covered Services under this Certificate, as limited by the Maximum Fee Schedule.

Maximum Fee Schedule - the lesser of:

- the Provider's Actual Charge for the service or supply; or

- the prevailing maximum allowable reimbursement schedule established by FCCI.

Medically Necessary or Medical Necessity - Covered Services that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, Injury, or disease; and

- Except as described in N.C. Gen. Stat. 58-3-255 for Covered Clinical Trials, not for Experimental/Investigational, or cosmetic purposes.

- Necessary for and appropriate to the diagnosis, treatment, care, or relief of a health condition, illness, Injury, disease or its symptoms.

- Within generally accepted standards of medical care in the community; and

- Not solely for the convenience of the Member, the Member's family or the Provider.

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

Medicare - a federal government program that provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities.

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

Noncertification - a determination by FCCI that a Hospital Stay, availability of care, continued stay, or other health care service, item or supply has been reviewed and, based upon the information provided, does not meet FCCI's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of Emergency Medical Condition, and the requested service is therefore denied, reduced, or terminated. A

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Noncertification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in this Certificate. A Noncertification includes any situation in which FCCI makes a decision about a Member's condition to determine whether a requested treatment is Experimental/Investigational, or cosmetic, if the extent of coverage under this plan is affected by that decision.

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

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

Open Enrollment Period - the period of time after the Employer enters into a Master Employer Agreement when Eligible Employees and Eligible Dependent(s) may Enroll in FCCI without being subject to the Pre-Existing Condition Exclusion.

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

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

Physician - a licensed medical doctor or Doctor of Osteopathy.

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

Precertification - a Certification requested from and issued by FCCI before the Member receives health care services.

Pre-Existing Condition - a physical or mental condition for which medical advice, diagnosis, care, or treatment was received or recommended within the 6 month period ending on the Enrollment Date, including conditions identified as a result of pre-enrollment questionnaires, examinations or medical record review. Genetic information in the absence of a diagnosis and pregnancy are not Pre-Existing Conditions.

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Pre-Existing Condition Exclusion - the denial of coverage for Pre-Existing Conditions for a period of time after Enrollment.

Prescription Drugs - any drug, product or device approved by the U.S. Food and Drug Administration, and required by law to be dispensed only by prescription, and which is dispensed pursuant to a prescription order or refill. Prescription Drugs will include injectable insulin, and compound prescriptions when the compound contains at least one Prescription Drug.

Primary Care Provider (PCP) - a Provider who:

- is practicing family or general medicine, obstetrics and gynecology, internal medicine or pediatrics; or, is a specialist when the Member has a serious or chronic degenerative, disabling, or life-threatening condition (the Member's Copayment amount is not changed in such event);

- is chosen by the Member to be responsible for coordinating the overall health care needs of the Member; and

- is a Participating Provider.

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

Psychiatric Day Treatment Center - a Health Service Facility licensed by the State of North Carolina to provide outpatient psychiatric services.

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

Self Employed Individual - means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years.

Service Area - the counties where FCCI is approved to provide health maintenance organization services.

Skilled Nursing Facility - an institution, or a part of an institution, that:

- is a Provider of skilled nursing care for people with sickness and injuries;

- has nursing services 24 hours a day that are supervised by a physician or a registered nurse who is employed full-time;

- keeps clinical records on all patients;

- has a Physician on call for emergency care; and

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- uses proper methods and procedures for providing needed drugs.

Small Employer - any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed no more than 50 persons, the majority of whom were employed within this state and meets all other eligibility requirements of applicable laws. In determining the number of employed persons, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. The term Small Employer includes Self-Employed Individuals.

Special Enrollment/Enrollee - an Enrollment by an Eligible Employee or an Eligible Dependent who meets certain conditions without being subject to a Pre-Existing Condition Exclusion.

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

Subscriber - a person enrolled in an FCCI plan as an employee of an employer group that has contracted with FCCI for health benefits.

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

Utilization Management Program - FCCI's program designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities.

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

ELIGIBILITY AND ENROLLMENT

Subscriber Enrollment

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

Employers may hold only one Open Enrollment Period, which will occur after the Master Employer Agreement is entered into. Except for Special Enrollments (described below), Eligible Employees and Eligible Dependents may Enroll only at the annual renewal date of the Master Employer Agreement. Those who do not Enroll during the Open Enrollment Period and Enroll at the annual renewal date will be considered Late Enrollees.

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For new hires after the Open Enrollment Period, the Employer will determine an Eligible Employee's Eligibility Date. The Employer may have a Waiting Period that must be satisfied before coverage is in effect.

Enrollment must be within 31 days from the Eligibility Date. The effective date of coverage will be the Eligibility Date if Enrollment is on or before that date. If Enrollment is after the Eligibility Date, coverage will begin on the first of the next month. For example, if an employee's Eligibility Date is May 21 and he enrolls on June 3, his effective date is July 1.

Enrollment Forms provided by FCCI must be completed and signed in order for coverage to become effective. ID Cards will be issued to each Member with the Enrollment Date and other important information about benefits.

Dependent Enrollment

Only Eligible Dependents may be Enrolled by the Subscriber. FCCI may request proof of Eligible Dependent status from time-to-time. As to any person whose coverage may be continue past the usual age limitation because such person is no longer a child but is not capable of self-support as a result of mental retardation or a physical handicap (as described under the definition of Eligible Dependent), proof of such mental retardation or physical handicap will only be required within 31 days of the child's attainment of the limiting age, but not more frequently than annually. If proof is not provided when requested, the dependent may not be Enrolled or may be Disenrolled.

If a Subscriber has an Eligible Dependent when the Subscriber Enrolls, the Enrollment Date for the Eligible Dependent will be the same as the Subscriber's if Enrolled within 31 days of the Eligibility Date.

Eligible Dependents added after the Subscriber's Enrollment due to or marriage, birth, adoption or placement for adoption or Foster Care placement may be Enrolled within 31 days of the date of those events. If not Enrolled within 31 days, the Eligible Dependent may not Enroll until the next annual renewal period and will be considered a Late Enrollee. The 31 day time limit does not apply if an enrollment is due to a Qualified Medical Child Support Order (explained below), or when the Enrollment of the Eligible Dependent does not result in any increase in the premium.

Services received from a Non-Participating Provider will not be Covered Services unless the services are Emergency Services or are not available from a Participating Provider without unreasonable delay. This rule applies even if the Member is an Eligible Dependent who does not live or work near Participating Providers, such as when he or she is living in a dormitory at school.

The maximum age limit for Eligible Dependents is shown in the Schedule of Medical Benefits.

Qualified Medical Child Support Orders

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

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Pre-Existing Condition Exclusion For Late Enrollees

Individuals who choose not to Enroll during the Open Enrollment Period and who Enroll at an annual renewal of the Master Employer Agreement are considered Late Enrollees.

Late Enrollees are subject to an 18 month Pre-Existing Condition Exclusion. This means that if a Member has a Pre-Existing Condition before Enrollment, he/she might have to wait up to 18 months before FCCI will provide benefits for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6 month period ending on the Enrollment Date. If the Employer has a Waiting Period, the 6 month period ends on the day before the Waiting Period begins.

For Late Enrollees, the Pre-Existing Condition Exclusion period may last up to 18 months from the first day of Enrollment or the first day of a Waiting Period. However, the length of this period can be reduced by the number of days a Member had prior Creditable Coverage. Most prior health coverage is Creditable Coverage and can be used to reduce or eliminate the Pre-Existing Condition Exclusion period if the Member has not had a break in coverage of more than 63 days. FCCI will not impose any Pre-Existing Condition Exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the Member held prior Creditable Coverage and the condition was covered under the prior Creditable Coverage, provided that such prior Creditable Coverage was continuous to a date not more than 63 days before the Enrollment Date.

The Pre-Existing Condition Exclusion does not apply to a child who is Enrolled within 31 days after birth, adoption, or placement for adoption or a Foster Child, or where such child was Enrolled automatically because addition of the child resulted in no increase in premium. Children Enrolled under a QMCSO are not subject to the Pre-Existing Condition Exclusion.

A Late Enrollee can provide FCCI with a copy of any Certificates of Creditable Coverage received from any previous health plan or insurer. If no Certificate of Creditable Coverage was provided, but a Member did have prior health coverage, FCCI will try to help the Member obtain one from the previous health plan or insurer. There are other ways of showing Creditable Coverage. Members may contact FCCI if they need help proving Creditable Coverage.

Any questions about the Pre-Existing Condition Exclusion and Creditable Coverage should be directed to FCCI Member Services at the FCCI main office telephone number under "Important Telephone Numbers".

Special Enrollment

Eligible Employees and their Eligible Dependents may Enroll at certain times other than during the Open Enrollment Period or at annual renewals without being subject to the Pre-Existing Condition Exclusion. Under federal law, if an Eligible Employee does not Enroll in FCCI on his/her Eligibility Date because he/she is enrolled in another employer-sponsored plan, and loses the other coverage due to:

- termination of employment,
- termination of the other plan or the Employer contribution,

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- death of the other employee;
- legal separation or divorce;
- loss of Eligible Dependent status;
- residing, living or working outside of an HMO service area;
- uniform termination of coverage by the insurer;
- cessation of benefits to a class of similarly situated individuals including the Eligible Employee or Eligible Dependent;
- exceeding the lifetime limits on benefits; or
- exhaustion of COBRA coverage.

The Eligible Employee and any Eligible Dependents may Enroll without the Pre-Existing Condition Exclusion. Additionally, FCCI will allow an Eligible Employees and Eligible Dependents to Enroll if coverage under the other plan has a significant change in cost or benefits, without being subject to the Pre-Existing Condition Exclusion.

In addition to the loss of coverage events triggering the Special Enrollment rights listed above, if an Eligible Employee who previously did not Enroll adds an Eligible Dependent due to marriage, birth, adoption or placement of an adopted child or a Foster Child, the Eligible Employee and Eligible Dependents are considered Special Enrollees.

All Special Enrollments must be requested within 31 days of the events described above.

Enrollment Changes

The Subscriber must notify FCCI of any additions, changes, or deletions to Enrollment as a result of the following:

- Marriage or divorce;
- Birth or death;
- Adoption decree or court-ordered temporary custody resulting from adoption proceedings;
- Addition of a step-child;
- Addition of a Foster Child;
- Permanent legal custody of a child;

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- Return to civilian status from active military personnel or change from civilian status to active military personnel;

- A change in Eligible Dependent status; or

- Eligibility for Medicare.

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

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

When Enrollment Ends
Enrollment of the Subscriber and all Enrolled Eligible Dependents ends on the date on which the Master Employer Agreement is terminated.

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

Enrollment of a dependent ends when he/she is no longer an Eligible Dependent, such as when he/she is age 26 or over. The date of Disenrollment is the last day of the month in which eligibility is lost, unless the Employer elects otherwise. The Employer also may elect to end dependent coverage. The date of Disenrollment will be the last day of the month in which premiums for dependent coverage are paid.

If Enrollment ends because of termination of employment or loss of Eligible Dependent status, Members may elect Continuation Coverage. See the "Continuation Coverage and Conversion Privilege" section of this Certificate.

A Member also may be Disenrolled upon written notice by FCCI of the following:

- Knowingly providing false or incomplete information to FCCI with fraudulent intent;

- Engaging in conduct that interferes with providing Covered Services; or

- Permitting the use of the FCCI ID Card by another person.

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

Except where Continuation Coverage is elected, FCCI has no responsibility for payment for any health services provided after the date of Disenrollment, regardless of the reason for Disenrollment.

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Certificates Of Coverage
When a Member Disenrolls from FCCI, including at the end of a Continuation Coverage period, FCCI will provide a Certificate of Creditable Coverage so that the Member can show proof of Creditable Coverage. Members also may request a Certificate of Creditable Coverage from FCCI up to 24 months from the date of Disenrollment.

GENERAL INFORMATION ABOUT BENEFITS

Services received from a Non-Participating Provider will not be Covered Services except for Emergency Services or when a Participating Provider is not able to meet the health needs of a Member without unreasonable delay as determined by FCCI's network access standards. If the Member believes that a Participating Provider is not available without unreasonable delay, the Member is encouraged to contact FCCI prior to receiving services from a Non-Participating Provider. FCCI will tell the Member whether the services will be Covered Services.

Only health care services and supplies for an illness or Injury are Covered Services, and only when:

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

Member Cost Sharing
Member payments, such as Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums, are listed on the Schedule of Medical Benefits. Most Covered Services require a payment to the Provider by the Member at the time of service. Copayments do not count toward Out-of-Pocket Maximums or Deductibles.

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

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

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

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REQUIRED NORTH CAROLINA NOTICE: Your actual expenses for Covered Services may exceed the stated Coinsurance or Copayment amount because actual Provider charges may not be used to determine FCCI's and Member's payment obligations. This will occur only in the unlikely event that the Member receives Covered Services from Non-Participating Providers for which FCCI is not required to, but elects to, treat the services as Covered Services.

About Selecting Providers

Participating Providers change from time to time. Just because a Participating Provider is listed in the Provider Directory does not guarantee that the Provider is still in FCCI's network at the time services are provided. It is recommended that Members call FCCI Member Services to confirm a Provider's status.

Primary Care Providers

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

Specialists

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

Continuity of Service

Newly enrolled Members or Members whose treating Provider is terminated as a Participating Provider for reasons other than fraud or failure to meet applicable quality standards, and who have an ongoing special condition as defined below, must be offered the opportunity to continue care with their current Provider for a transitional period not to exceed 90 days, with some exceptions described below. FCCI will comply with the following requirements of North Carolina law regarding continuity of care for HMO members who are not enrolled in a point of service plan.

The following definitions apply to this discussion:

- "Ongoing special condition" means:
  - In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
  - In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
  - In the case of pregnancy, pregnancy from the start of the second trimester.
  - In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

- "Terminated or termination" includes, with respect to a Provider contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by for failure to meet applicable quality standards or for fraud.

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- "Transitional period" means an up to 90 day period, as determined by the treating Provider, after the date of the notice to Member described below, or the Enrollment Date.

Procedure

If a Participating Provider contract between FCCI and a Provider is terminated, or benefits or coverage provided by FCCI are terminated because of a change in the terms of Provider participation, and a Member enrolled in an HMO plan is undergoing treatment from the Provider for an ongoing special condition on the date of the termination, then FCCI shall:

- Notify the Member on a timely basis of the termination and of the right to elect to continue treatment by the Provider if the Member has filed a claim for services related to an ongoing special condition or the member is otherwise known by FCCI to be a patient of the Provider.

- Subject to requirements below, permit the Member to elect to continue to be Covered with respect to the treatment by the Provider of the ongoing special condition during a transitional period.

FCCI will Cover services required for an ongoing special condition for newly enrolled HMO plan members who are undergoing treatment from a Non-Participating Provider. FCCI shall:

- Notify the Member on the date of enrollment of the right to elect continuation of coverage of treatment by a Non-participating Provider.

- Subject to the requirements below, permit the Member to elect to continue to be treated by the provider for the ongoing special condition during a transitional period.

The transitional period may be extended for the following categories of Members:

- For Members scheduled or on an established waiting list for surgery, organ transplantation, or other inpatient care before the date of any required notice or new enrollment, the transitional period will be extended through the date of discharge and through post-discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

- For Members who have entered the second trimester of pregnancy on the date of required notice or new enrollment, the transitional period shall extend through the provision of 60 days of postpartum care.

- For Members determined to be terminally ill at the time of a Provider's termination or new enrollment, the transitional period shall extend for the remainder of the Member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

FCCI may condition coverage of continued treatment by a Non-Participating Provider upon the following:

- The Provider must agree to accept FCCI's then current Maximum Fee Schedule and comply with all applicable provisions of the plan regarding Member responsibility payments.

- The Provider agrees to comply with FCCI's utilization management program.

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- The Provider agrees otherwise to adhere to FCCI's established policies and procedures for Participating Providers, including procedures regarding certifications, providing services pursuant to a treatment plan, if any, approved by FCCI, and Member hold harmless provisions.

- The Provider agrees to discontinue providing services at the end of the transition period and to assist the member in an orderly transition to a Participating Provider

The Member or Member's representative must notify FCCI in writing within 45 days of the date of the notice or the new enrollment of the election to continue receiving treatment by a Non-Participating Provider.

COVERED SERVICES

Services received from a Non-Participating Provider will not be Covered Services unless Emergency Services are received or the services are not available from a Participating Provider without unreasonable delay.

Wellness and Preventive Services

The following are Covered Services:

- Well-child care;

- Yearly vision screening for children ages 1-17 in a PCP's office;

- Newborn hearing screening ordered by an attending Physician for the presence of permanent hearing loss;

- Periodic hearing screening examinations for children through age 17;

- Periodic health assessment for adults (including annual well woman examinations);

- Child and adult immunizations according to accepted medical practice;

- Examinations and laboratory tests for the early detection of cervical cancer in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Examinations and laboratory tests that are Covered Services are conventional PAP smear screening, liquid-based cytology, and human papilloma virus (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;

- Mammograms - when a Provider recommends it for anyone at increased risk for breast cancer, OR

  One baseline mammogram at ages 35 through 39 and every year at age 40 and older;

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- Prostate Specific Antigen (PSA) tests when a Provider recommends it;
- Bone mass measurement, if at least 23 months have elapsed since the last measurement was performed OR more frequently if Medically Necessary;
- Diabetes outpatient self-management training and educational services;
- Colorectal cancer examinations and laboratory tests for cancer, in accordance with the American Cancer Society guidelines, for any non-symptomatic Member who is at least 50 years of age, or less than 50 years of age and at high risk for colorectal cancer;
- Surveillance tests for women age 25 and older at risk for ovarian cancer. "At risk for ovarian cancer" means either:
    - having a family history with at least one first-degree relative with ovarian cancer; and
    - a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
    - testing positive for a hereditary ovarian cancer syndrome.

  "Surveillance tests" mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination.

Coverage for Certain Treatment of Diabetes
Coverage will be provided for equipment, supplies and laboratory procedures used to treat diabetes.

Physician Services and Office Visits
Examinations, treatment and consultations by Physicians and other licensed practitioners under the supervision of a Physician are Covered Services. Covered Services also include Medically Necessary items and supplies provided or administered during an office visit.

Emergency Services
If a Member believes that he/she has an Emergency Medical Condition, he/she should seek care from the nearest Health Service Facility. "911" emergency telephone access systems or other community emergency alert systems should be used where available. Emergency Services are Covered Services whether received from a Participating or Non-Participating Provider.

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

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

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For routine and follow up care related to an Emergency Medical Condition to be Covered, the Member must use a Participating Provider. Precertification requirements may apply.

If a Member is admitted for a Hospital Stay directly from the emergency department, FCCI should be notified of the condition and the services that the Member is receiving as soon as medically appropriate by calling the toll free Member Services number. The Hospital Stay will be Covered until the Member can be transferred to a Participating Provider. If the Member does not transfer to a Participating Provider when medically appropriate, then FCCI may, at its option, determine that no benefits will be paid for the remaining Hospital Stay.

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

Hospital Stay other than Maternity Care
Hospital Stays, which include all Medically Necessary services and supplies furnished by the Hospital, Physician services, diagnostic services and room and board for a semi-private room, are Covered.

Room and board for a private room is Covered if:

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

Outpatient Services and Surgery
FCCI will Cover health services provided in an outpatient setting in a licensed Health Service Facility, such as chemotherapy, diagnostic procedures and ambulatory surgery.

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

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

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

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

- Non-Custodial Care provided in the home;
- Provided by health professionals;
- Supervised by a Physician;
- Provided by a Home Health Care agency approved by FCCI; and
- Provided to a Member Precertified by FCCI as homebound; that is, unable to leave home for more than short, infrequent non-medical purposes without considerable and taxing effort.

Short-term Outpatient Rehabilitation Service
Short-term outpatient occupational therapy, physical therapy and chiropractic services are Covered. Short-term speech therapy to restore speech loss due to sickness or Injury are Covered. Members may receive services in a Hospital outpatient department, Physicians' office, or a freestanding therapy center. Rehabilitation services are Covered for conditions that, in FCCI's judgment, are reasonably expected to improve in the short-term. The Schedule of Medical Benefits lists the limits for each service.

Imaging and Laboratory Procedures
Imaging and laboratory services at freestanding Health Care Facilities, Hospital outpatient departments or Providers' offices are Covered. This includes:

- X-rays to diagnose or treat conditions,
- Fluoroscopy, ultrasound, EEGs, EKGs,
- MRIs, PET and CT scans, and
- Laboratory tests.

Reproduction Related Services
Maternity Care

Maternity care is Covered only for the Subscriber and the Subscriber's spouse (if the spouse is a Member). Covered Services include:

- Prenatal care;
- Hospital Stays;
- Birthing center care;

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- Physician or other attending Provider services;
- Post-delivery Care for the mother and baby if the mother and attending Provider agree to a discharge prior to 48 hours after normal delivery or for up to 96 hours after Caesarean section; and
- Services for the baby for the duration of the mother's Hospital Stay after childbirth.

No Precertification is required for Hospital Stays for the mother and baby for up to 48 hours after normal delivery or for up to 96 hours after Caesarean section. Hospital Stays in excess of those periods require Precertification.

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

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

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

Family Planning
Covered Services include examinations, consultations, procedures and other services relating to the use of contraceptive methods for the prevention of pregnancy. Covered contraceptives include intrauterine devices, diaphragms, injectable and implantable contraceptives. Removal of devices that must be removed by a Provider is Covered.

Behavioral Health Services
Hospital Stays for Behavioral Health Services are Covered. Coverage includes room and board, Physician and other Medically Necessary services. The maximum number of Covered days per Calendar Year is listed in the Schedule of Medical Benefits. Each day in a Psychiatric Day Treatment Center will be counted as one-half day toward the Calendar Year limit for Hospital Stays for Behavioral Health Services.

Behavioral Health Services provided on an outpatient basis are Covered as needed for short-term evaluation or crisis intervention. The maximum number of visits per Member per Calendar Year is listed in the Schedule of Medical Benefits.

Chemical Dependency Services
Hospital Stays for diagnosis and medical treatment for Chemical Dependency are Covered. Coverage includes room and board and appropriate professional services furnished by Chemical Dependency Treatment Providers.

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The maximum amount that will be paid for all Hospital Stays to receive Chemical Dependency treatments per Member per Calendar Year is listed in the Schedule of Medical Benefits. The total amount that will be paid for Chemical Dependency is limited during the entire time the person is a Member to the amount listed in the Schedule of Medical Benefits.

Outpatient diagnosis and medical treatment of Chemical Dependency by a Chemical Dependency Treatment Provider are Covered as needed for short-term evaluation or crisis intervention. The maximum number of Covered visits per Member per Calendar Year is listed in the Schedule of Medical Benefits.

Diagnostic Services for Developmental Delays or Learning Disabilities
The following are Covered for Members who are minors:

- The initial diagnostic work-up to diagnose a developmental delay disorder or learning disability;
- Up to six (6) parent-child education classes for ADD/ADHD; and
- Management of ADD/ADHD medication.

Treatment of the Bones or Joints of the Jaw, Face or Head
Diagnostic, therapeutic or surgical procedures involving bones or joints of the jaw, face or head are Covered. This benefit is subject to any lifetime maximum dollar amount applicable to the non-surgical treatment of temporomandibular joint dysfunction and craniomandibular pain syndrome.

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

- Injury to sound natural teeth, when treatment is received within 12 months after the Injury. Treatment of Injuries resulting from eating or chewing are not Covered; and
- Health Service Facility and anesthesia related charges incurred in connection with Dental Services are Covered for children less than 9 years old, persons with serious mental and physical conditions, and persons with serious behavioral problems.

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

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

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Repair or replacement of the equipment will not be Covered if:

- It is needed as a result of abuse; or
- The equipment was used for purposes for which it was not intended.

The maximum rental price cannot exceed the purchase price.

Prosthetics/Orthotics
A prosthetic is an artificial device attached to the body to replace a missing part and to aid its function. An orthotic is a support, brace or splint used on the order of a Provider to support, align or correct the function of a moveable part of the body. The first purchase of a permanent prosthetic device and a "training" device will be Covered, subject to the approval of FCCI. The first purchase of an orthotic will be Covered, subject to the approval of FCCI. Replacements will not be Covered due to loss, theft, or destruction. Replacements needed due to growth or normal wear and tear will be Covered subject to FCCI approval, and limited to one per Calendar Year. Prosthetics and orthotics are subject to limitations described in the Schedule of Medical Benefits.

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

Prescription Drugs
Prescription Drugs are Covered only if the Master Employer Agreement includes a Prescription Drug Rider, except that the following services are Covered whether or not a Prescription Drug Rider is included:

- Insulin and Prescription Drugs for the treatment of diabetes; and
- Covered allergy injections, chemotherapy and other Prescription Drugs administered in a Provider's office.

Covered Clinical Trials
Covered Clinical Trials must meet applicable requirements in this Certificate as well as the following:

- Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
- Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs;

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- Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients; and

- Must be provided only to Members who meet the protocol requirements of the Covered Clinical Trial and provide informed consent.

Medically Necessary costs of health care services associated with participation in the Covered Clinical Trial are Covered. FCCI does not Cover:

- Health services that are not Medically Necessary;

- Services provided solely to satisfy data collection and analysis needs;

- Expenses for Experimental/Investigational drugs or devices;

- Services not provided for the direct clinical management of the Member;

- Services or supplies supported or funded by national agencies, commercial manufacturers, distributors or other research sponsors of participants in such clinical trials; or

- Non-FDA approved drugs provided or made available to a Member who received the drug during a Covered Clinical Trial after the Member's participation in the Covered Clinical Trial has been discontinued.

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

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

As used in this section, mastectomy means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

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

- Reestablish symmetry between the two breasts;

- Reconstruct the mastectomy site;

- Create a new breast mound;

- Reconstruct the nipple and area around it; and

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- Reduce or enlarge the non-diseased breast's size.

Gastric Surgery
FCCI will Cover gastric surgery when:

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

The benefit limit for Covered gastric surgery is listed in the Schedule of Medical Benefits.

Organ and Tissue Transplants
If a Member is recommended to receive an organ or tissue transplant, the Member or his/her Physician must contact FCCI prior to the scheduling of the transplant surgery. Transplants are Covered if provided by transplant centers approved by FCCI.

Covered transplants are:

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

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

Covered Services received by the Member related to the Member's transplant will be provided at the same level as any other condition.

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

- A functional defect that results from a birth defect; or

- A seriously disfiguring condition resulting from Injury.

Other Services

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

- The service is approved by FCCI's Medical Management Program as a safer and more cost-effective treatment than what would otherwise be provided;

- FCCI approval is given prior to the services being provided; and

- The treatment is agreed to by the Member, the Member's attending Provider, and FCCI.

EXCLUSIONS AND LIMITATIONS

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

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

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

- Health services for Injury sustained while a Member is engaged in or participating in an act that has been prosecuted or may be prosecuted as a misdemeanor or felony by an appropriate law enforcement agency.

- Services, treatment or supplies in a Health Service Facility, or part of a facility, that is mainly a place for (a) rest, residence or assisted living; (b) convalescence; (c) Custodial Care; (d) the aged; or (e) training or schooling.

- Experimental/Investigational treatment, services, drugs or supplies, including any related diagnostic services, exams or supplies and regardless of the applicable sickness or Injury. This exclusion does not apply to Covered Clinical Trials.

- Purchase or fitting of glasses or contact lenses, except for one pair immediately following cataract surgery.

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

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

- Dental Services, except those specifically listed as Covered in "Covered Services", treatment related to dentures, orthodontic services and orthagnathic surgery.

- Services, treatment or supplies for obesity, weight reduction or weight control, except surgery that meets the requirements for "Gastric Surgery" under "Covered Services."

- Services, treatment or supplies for weak, strained or flat feet, or instability or imbalance of the feet, including orthopedic shoes or other supportive devices or for cutting, removal or treatment of corns, calluses or toe nails.

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

- For Late Enrollees, charges for services, treatment or supplies for any Pre-Existing Condition for a period of up to 18 months after the Enrollment Date, subject to the terms described in "Late Enrollees and Pre-Existing Condition Exclusion" section.

- Cosmetic surgery. This means any surgery done primarily to improve the appearance of any part of the body and not to improve physical function. Some examples are:

  - surgery for sagging or extra skin;

  - any enlargement or reduction procedures;

  - rhinoplasty and associated surgery; and

  - any procedures utilizing an implant that does not change physical function or is not incident to a surgical procedure.

  This exclusion does not apply to reconstructive surgery following an Injury.

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

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

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

- Private duty nursing.

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

- Reversal of surgical sterilization.

- Genetic testing, except for amniocentesis if Medically Necessary.

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

- Marriage counseling, other than for acute crisis intervention.

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

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

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

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

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

- Orthomolecular therapy including but not limited to nutrients, vitamins and food supplements and any nutritional supplement or meal replacement product.

- Speech therapy except to restore speech loss due to sickness or Injury.

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

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- Prescription Drugs or non-Prescription Drugs dispensed in a Provider's office.
- Charges for medical reports or for the completion of forms unless requested by FCCI.
- Examinations for obtaining or maintaining employment, insurance, professional, or other licenses, school exams and sports physicals.
- Appearances at hearings and court proceedings by a Provider.
- Services, treatment or supplies for mental retardation, behavioral developmental delay disorders or learning disabilities except limited diagnostics and education expressly listed under "Covered Services."
- Immunizations for international travel.
- Travel and transportation expenses. Travel and transportation expenses related to transplants may be Covered when approved by FCCI.
- Sclerotherapy (injection of sclerosing solutions) for the treatment of varicose veins.
- Charges for missed or canceled appointments.
- Any service, supply or treatment for which a chelating agent is used except for the treatment of heavy metal poisoning.
- Any service, supply or treatment in excess of the Benefit Year or Lifetime maximum as stated in the Schedule of Medical Benefits.
- Covered Services for which payment has been made under Medicare or any other federal, state or local government program (excluding Medicaid).
- Services, treatment or supplies not specifically described as Covered Services.
- Services, treatment or supplies for sexual offenders or perpetrators of sexual or physical violence.
- Medical or surgical complications resulting from a non-Covered service.
- Extra charges above the usual fee for obtaining, storing or administering donated blood. This includes a Member arranging for blood donations to be used by the Member at a future time.
- Hearing exams, tests, hearing aids and other routine hearing care services, treatments and supplies other than Covered hearing exams for newborns and children under the age of 17.
- Purchase or fitting of corrective shoes, devices, or appliances unless Medically Necessary and approved by FCCI.

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- Prescription Drugs, except as listed in “Covered Services”, unless the Employer purchased a Prescription Drug Rider to be included with this Certificate.

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

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

MEDICAL MANAGEMENT

Procedures For Precertification

A current list of services and items that require Precertification is included with this Certificate as Attachment A.

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

- Member name;

- Member ID number;

- The name and address of any Hospital or Health Service Facility to be used; and

- Treating Provider's name.

Important Note: An additional 20% Coinsurance penalty will be applied to Claims where no Precertification is issued by FCCI before the Member receives services requiring Precertification. The amount of this penalty does not count toward the Out-of-Pocket Maximum.

No Precertification is needed for Emergency Services.

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

Procedures For Certification

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

FCCI shall notify the Member of the Certification decision (whether adverse or not) within 3 days after receipt of the claim, unless the request is for Emergency Medical Services.

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

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

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

Expedited Precertifications And Certifications

Members have the right to a more rapid or expedited decision on a Precertification or Certification request if following the standard time limits would, in the opinion of a prudent layperson with an average knowledge of health and medicine, or in the opinion of a Physician with knowledge of the Member's condition:

- Seriously jeopardize the life or health of the Member,

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- Jeopardize the Member's ability to regain maximum function, or
- Subject the Member to severe pain that cannot be adequately managed without the services subject to the appeal.

In these cases, FCCI will give the Member a decision (whether adverse or not) as soon as possible, taking into account the medical situation, but not later than 72 hours after FCCI received the request unless the Member fails to provide necessary information.

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

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

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

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

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

Participating Providers will submit Claims to FCCI on the Member's behalf. Unless special circumstances apply, (as described above, especially under “Covered Services” and “Exclusions and Limitations”), services from Non-Participating Providers usually are not covered. Even in cases where their services are Covered Services, however, Non-Participating Providers may require payment at the time of service and the Member may be responsible for filing the Claim. When submitting a Claim for services provided by a Non-Participating Provider, Members must submit copies of bills for all charges. Except as described below under "Assignment of Benefits", these benefits may be paid directly to the Provider. Claim forms may be obtained from the Employer or FCCI.

The Member or the Provider must mail the Claim to FCCI within 180 days after the date of service. Services for which a Claim is not received within 180 days after the date of service will not be a Covered Service unless it was not reasonably possible for the Claim to be filed within the 180 day period. In such case, the Claim must be filed as soon as reasonably possible but in no case later than one (1) year from the time submittal of the claim is otherwise required, except in the absence of legal capacity of the Member. This 1 year extension, if applicable, does not require FCCI to make payments to Participating

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Providers whose contracts allow a shorter period in which to file claims. However, the 1 year extension stated in this paragraph will be applied to any claims filed by Members for Covered Services rendered by Non-Participating Providers.

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

FCCI may, from time to time, identify certain Non-Participating Providers to which a Member cannot assign benefits under this Certificate. The Employer will be given a written list of such Providers. If a Member receives Covered Services from these Providers, FCCI will issue payment to the Member rather than to the Provider, even if a Member has authorized benefits to be assigned to the Provider.

COORDINATION OF BENEFITS

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

- The plan covering a person as an employee is primary.
- The plan covering a person as a spouse is secondary.
- The plan covering a child as a dependent of the parent whose birth date falls first during the year is primary.
- If both parents have the same birth date, the plan that has covered a parent for the longer period of time will be primary.
- If the parents are divorced or separated, the plan that covers the child as a dependent of the parent with custody is primary.
  - The plan that covers the child as a dependent of the spouse of the parent with custody is primary to-
  - The plan that covers the child as a dependent of the parent without custody.
- If there is a court order that requires a parent to purchase the child's health coverage and FCCI has knowledge of the court order, then that plan will be primary.

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- A plan that covers a person other than as a laid-off or retired employee or as a dependent of other than a laid-off or retired employee is primary to a plan that covers the person as a laid-off or retired employee (unless this results in a conflict in determining order of benefits).

- If none of the above rules apply, the plan that has covered a person the longest is primary.

- If the other plan does not have rules that establish the same order of benefits as FCCI, then that plan will be primary.

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

Facility Of Payment

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

Right Of Recovery

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

- The persons it has paid or for whom it has paid;

- Insurance companies; or

- Other organizations.

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

Coordination With Medicare

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

CONTINUATION OF COVERAGE AND CONVERSION COVERAGE

Generally

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

- Continue coverage under federal or state law; or

- Conversion coverage.

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

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Continuation Coverage
The Employer is responsible for determining if Members are eligible to continue health coverage under either state or federal law, described below.

Continuation Coverage under Federal Law
This section contains important information about rights to COBRA Continuation Coverage, which is a temporary extension of coverage under this Certificate. What follows explains COBRA Continuation Coverage, when it may be available and what to do to protect the right to receive it.

The right to COBRA Continuation Coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA" for short). COBRA Continuation Coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary". The Subscriber and Eligible Dependents could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

When COBRA Continuation Coverage is Available
A Subscriber will become a qualified beneficiary if he/she loses coverage under this certificate because either one of the following qualifying events happens:

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

A spouse of a Subscriber can become a qualified beneficiary if:

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

Other Dependents can become qualified beneficiaries if they lose coverage because:

- The Subscriber parent dies;
- The Subscriber parent's hours of employment are reduced;
- The Subscriber parent's employment ends for any reason other than gross misconduct;

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- The Subscriber parent becomes entitled to Medicare benefits (under Part A or B or both); or
- The Subscriber and spouse are divorced or legally separated; or
- The dependent stops being an Eligible Dependent.

COBRA Continuation Coverage will be offered to qualified beneficiaries only after FCCI is notified that a qualifying event has occurred. When the qualifying event is the reduction of hours, termination of employment, death of the Subscriber or the Subscriber's becoming eligible for Medicare, then the Employer must notify FCCI.

For other qualifying events (divorce or legal separation or loss of Eligible Dependent status, the Subscriber must notify FCCI within 60 days after the qualifying event occurs. Notice must be provided to the FCCI COBRA Coordinator at the telephone number or address below, along with copies of verifying documents.

Enrollment in COBRA Continuation Coverage
Once FCCI gets notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries, who will have an independent right to elect COBRA Continuation Coverage. Subscribers may elect on behalf of the non-Subscriber spouse and parents may elect on behalf of their Eligible Dependents. FCCI will send the election notice within 14 days of notice of the qualifying event. Qualified beneficiaries will have 60 days in which to respond to the election notice.

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

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

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

- Disability Extension

  If a qualified beneficiary is determined by the Social Security Administration to be disabled and FCCI is notified timely, the qualified beneficiaries may be entitled to receive up to an additional 11

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months of COBRA Continuation Coverage, for a maximum of 29 months. The qualifying disability must have started during the first 60 days of COBRA Continuation Coverage and must last at least until the end of the 18 month period. Notice of the disability determination must be provided to the FCCI COBRA Coordinator.

- Second Qualifying Event Extension

  If the Subscriber or Eligible Dependents has another qualifying event during the 18 month period, they may be eligible for up to 18 more months, for a maximum of 36 months of COBRA Continuation Coverage. This extension is available if, during the first 18 month Continuation Coverage period, the Subscriber or former Subscriber dies, becomes entitled to Medicare, gets divorced or legally separated, or if the dependent loses Eligible dependent status, but only if these events would have caused the Subscriber or Eligible Dependents to lose coverage if the first qualifying event would not have occurred.

Address Changes
In order to protect Member's rights under COBRA, it is important to notify the Employer and FCCI of any address changes for Subscribers and Eligible Dependents. Members also should keep copies of any notices sent to the Employer or to FCCI.

More Information
Questions about COBRA Continuation Coverage rights should be addressed to the contacts below. For more information about rights under ERISA, including COBRA, the health Insurance and Portability and Accountability Act (HIPPA) and other laws affecting group health plans, Members may contact the nearest regional or district office of the U.S. Department of Labor Employee benefits Security Administration (EBSA) in the local area or visit the website at www.dol.gov/ebsa.

FCCI Contact Information
The FCCI COBRA Coordinator may be reached at 910-715-8100 or by mail at

FirstCarolinaCare, Inc.
42 Memorial Drive
Pinehurst, NC 28374

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

The Subscriber may choose coverage for himself or herself and his or her Family Members in the event the coverage is lost due to termination of the employment or reduction in the hours of employment.

If entitled to state Continuation Coverage, the Subscriber must:

- Notify the Employer of any of the qualifying events listed above;

- Elect state Continuation Coverage within sixty (60) days after eligibility ends by notifying the Employer and paying the required initial premium; and

- Pay monthly premiums to the Employer when due.

- The Employer may charge an additional 2% administrative fee over the total premium rate for administration costs.

State Continuation Coverage is subject to these conditions:

- A Subscriber must be covered in the group plan for the entire three months just before the date coverage ends;

- A Subscriber will not be eligible if:

- Coverage ended because of a failure to pay the employee portion of the cost;

- The Subscriber is eligible for similar benefits under another health plan within 31 days after the end date of coverage; or

- The Master Employer Agreement ends and the Employer replaces it with similar coverage within 31 days.

If Continuation Coverage ends because the Master Employer Agreement ends, a Member may still be entitled to Conversion Coverage. This applies if the Member first continues coverage for 18 months.

- State Continuation Coverage will end:

- The date 18 months after the date the Subscriber lost eligibility;

- The date that ends the period for which premium was last paid;

- The date a Member becomes eligible for coverage under another group plan; or

The date the Master Employer Agreement ends. If the Employer replaces the Master Employer Agreement with another group plan, state Continuation Coverage may be continued under that group plan for the remaining period.

Conversion Coverage

North Carolina law provides for Conversion Coverage under certain conditions. If a Subscriber is no longer eligible for Continuation Coverage, he/she may elect Conversion Coverage within 31 days of the loss of Continuation Coverage. Other terms and conditions apply. Contact the Employer to find out more about Conversion Coverage through FCCI.

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MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

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

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

Member Responsibilities

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

- Comply with the requirements for coverage under this Certificate.
- Establish a Provider/patient relationship with a PCP.

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

Advance Directives
Advance Directives may contain instructions about the following:

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

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

Members will not be treated differently by FCCI or Provider based on whether or not there is an Advance Directive.

For more information on Advance Directives, Members should contact their Provider, lawyer, or a Member Service Representative.

COMPLAINTS, APPEALS AND GRIEVANCE PROCEDURES

Quality of Care Complaints

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

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

Standard Appeals

If a Member does not agree with a decision to deny Certification or Precertification of a health service, the decision may be appealed

Members have 180 days after the Member received the decision to request an Appeal of the denial of Certification or Precertification.

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

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

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

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Expedited Appeals

Members have the right to a more rapid or expedited Appeal of a Precertification or Certification decision if following the standard time limits would, in the opinion of a prudent layperson with an average knowledge of health and medicine, or in the opinion of a Physician with knowledge of the Member's condition:

- Seriously jeopardize the life or health of the Member,
- Jeopardize the Member's ability to regain maximum function, or
- Would subject the Member to severe pain that cannot be adequately managed without the services subject to the appeal.

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

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

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

The Member may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, 800-546-6554 (for residents of North Carolina only) or 919-733-2004 (for persons outside of North Carolina) for information about state laws regarding appeals.

Members also may contact the Managed Care Patient Assistance program by:

- email at MCPA@ncdoj.com;
- by telephone at 1-866-867-MCPA (6272) (toll-free for residents of North Carolina only) or 919-733-MCPA (6272) (for persons outside of North Carolina); or
- by writing to:

  Managed Care Patient Assistance
  Attorney General's Office
  9001 Mail Service Center, Raleigh, NC 27699-9001
  Physical Address: 114 West Edenton Street
  Raleigh, NC 27603

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

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Grievance Procedures

First Level Grievance

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

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

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

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

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

Second Level Grievance

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

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

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

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

- To ask and get from FCCI all information important to the review;

- To explain his/her position to the second level review panel;

- To submit supporting material prior to and at the review meeting;

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- To ask questions of any member of the review panel;

- To be helped or represented by a person of the Member's choosing, including a family member, Employer representative or lawyer; and

- To participate in the second level Grievance review via telephone conference.

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

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

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

The North Carolina Department of Insurance is available to assist consumers with insurance related problems and questions. Questions may be directed in writing to:

The North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
or by telephone at 800-546-5664.

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

External Review

In General

In addition to FCCI's Appeals and Grievance Procedures, North Carolina law provides for review of Noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this voluntary service at no charge to the public. The Member or his/her representative may request an External Review. FCCI will notify the Member in writing of the right to request an External Review at the time of receiving:

- A Noncertification decision,

- An Appeal decision upholding a Noncertification decision, or

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- A second level Grievance review decision upholding the original Noncertification.

Eligibility
In order for a Member to be eligible for External Review, the NCDOI must determine the following:

- That the request is about a medical necessity determination that resulted in a Noncertification decision,

- That the Member had coverage with FCCI in effect when the Noncertification decision was issued,

- That the service for which the Noncertification was issued appears to be a Covered Service under the Certificate, and

- That FCCI's internal review process have been exhausted as described below.

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

For a standard External Review, the internal review process is exhausted when a Member has:

- Completed FCCI's Appeal and second level Grievance review and received a written second level determination from FCCI, or

- Filed a second level grievance and unless the Member requested or agreed to a delay, have not received FCCI's written decision within 60 days of the date the request was submitted, or

- Received notification that FCCI has agreed to waive the requirement to exhaust the internal Appeal and/or second level Grievance process.

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

Standard External Review
If a Member wishes to request a standard External Review, he/she (or a representative) must make this request to NCDOI within 60 days of receiving FCCI's written notice of final determination that the services in question are not approved. When processing the request for External Review, the NCDOI will require a written, signed authorization for the release of any medical records that may need to be reviewed for the purpose of reaching a decision on the External Review.

Within 10 business days of receipt of the request for a standard External Review, the NCDOI will notify the Member and his/her Provider of whether the request is complete and whether it is accepted. If the NCDOI notifies a Member that the request is incomplete, the Member must provide all requested

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additional information to the NCDOI within 90 days of the date of FCCI's written notice of final determination. If the NCDOI accepts the request, the acceptance notice will include:

- The name and contact information for the Independent Review Organization (IRO) assigned to the Member's case,
- A copy of the information about his/her case that FCCI has provided to the NCDOI,
- Notice that FCCI will provide you with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO), and
- Notification that additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO may be accepted within 7 days of the date of the acceptance notice.

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

FirstCarolinaCare Insurance Company, Inc.
42 Memorial Drive
Pinehurst, NC 28374

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

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

Expedited External Review

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

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- Receives a Noncertification decision from FCCI AND file a request with FCCI for an expedited appeal, or

- Receives an appeal decision upholding a Noncertification decision AND file a request with FCCI for an expedited second level grievance review, or

- Receives a second-level grievance review decision upholding the original Noncertification.

The Member may also make a request for an expedited External Review if he/she receives an adverse second-level grievance review decision concerning a Noncertification of an admission, availability of care, continued stay or Emergency Services, but have not been discharged from the Health Service Facility.

In consultation with a medical professional, the NCDOI will review the request and determine whether it qualifies for expedited review. The Member and the Provider will be notified by the NCDOI within 3 business days if the request is accepted for expedited External Review. If the request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard External Review if FCCI's internal review process was already completed, or (2) require the completion of FCCI's internal review process before the Member may make another request for an External Review with the NCDOI. An expedited External Review is not available for retrospective Noncertifications.

The IRO will communicate its decision within 4 business days after receipt of the request for an expedited External Review. If the IRO's decision is to reverse the Noncertification, FCCI will, within one day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply. If the Member is no longer Enrolled in FCCI at the time FCCI receives notice of the IRO's decision to reverse the Noncertification, FCCI will only provide coverage for those services or supplies actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

The IRO's External Review decision is binding on FCCI and the Member, except to the extent other remedies are available under applicable federal or state law. The Member may not file a subsequent request for an External Review involving the same Noncertification decision for which a Member has already received an External Review decision.

Additional Information
The Healthcare Review Program is available to provide consumer counseling on utilization review and internal appeals and grievance issues. For information, contact the Healthcare Review Program at:

NC Department of Insurance
Healthcare Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201

In Person:
Dobbs Building
430 N. Salisbury St,
4th Floor, Suite 4105, Raleigh, NC

1-877-885-0231 (toll free in state)
1-919-807-6860 (out of state)
1-919-807-6865 (fax)

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Visit www.ncdoi.com/ER for External Review information and Request Form.

GENERAL PROVISIONS

Notices

To FCCI: Notices may be sent by U.S. Mail postage prepaid, addressed as follows:

FirstCarolinaCare Insurance Company, Inc.
42 Memorial Drive
Pinehurst, NC 28374

To Members: To the latest address provided on an Enrollment Form or on a change of address form received by FCCI.

Independent Contractor Relationship

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

Warranties

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

Waiver Of Certificate Provision

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

Unenforceability Or Invalidity Of Any Provision

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

Amendment And Termination

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

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Discretionary Authority

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

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ATTACHMENT A
SERVICES REQUIRING PRECERTIFICATION

Inpatient admissions except for maternity care or Emergency Services
All skilled nursing facility admissions
All inpatient rehabilitation admissions
All outpatient surgery
Surgery of the jaw, face or head
Reconstructive surgery
Gastric surgery
Anesthesia and Health Service Facility services related to Dental Services
Covered clinical trials
Injectable drugs received in an outpatient setting
Physical therapy
Occupational therapy
Speech therapy
Chiropractic care
Cardiac rehabilitation (outpatient)
Pain clinic
Cardiac catheterization
MRI/MRA
CT scans
Colonoscopy
Upper endoscopies
Endoscopic retrograde cholangiopancreatography (ERCP)
PET scans
Spect scans
Muga scans
Myelogram
Sleep studies
Allergy testing
Invasive radiologic services
Durable medical equipment with purchase price $250.00 or greater
Durable medical equipment rentals
Orthotics and prosthetics with purchase price greater than $250.00
Home Health Services
Behavioral Health and Chemical Dependency Services

This list may be amended by FirstCarolinaCare Insurance Company, Inc. from time to time. Notice of any changes will be provided to Members.

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