NORTH CAROLINDA SMALL EMPLOYER GROUP
BASIC INDEMNITY PLAN

SUMMARY OF BENEFITS

▪ Calendar Year Deductible:	$1,000
▪ Emergency Room Deductible:	$50 per visit, waived when admitted
▪ Carryover Deductible:	None
▪ Family Deductible Limit:	3 Family Members
▪ Out-of-Pocket Limit:	$3,000 per Insured per year (plus a $1,000 deductible)
▪ Family Out-of-Pocket Limit:	None
▪ Annual Maximum[i]:	$~~100,000~~750,000 per Insured
▪ ~~Lifetime Maximum:~~	~~$1,000,000 per Insured~~
▪ Benefit Percentage:	60% (unless noted otherwise)
▪ Wellness Benefit:	~~$100 per Insured per benefit period~~ Covered subject to deductible for any
	any services not included in Preventive Services under the Affordable Care Act.
▪ Preventive Services	100% to the extent the service is a "preventive health service" under the Affordable Care Act
▪ Maternity:	Insured employee and the insured dependent spouse only; paid as any other illness
▪ ~~Lifetime Mental & Nervous Disorder Maximum: (including Chemical Dependency)~~	~~$10,000 per Insured~~
▪ Inpatient Mental & Nervous Disorder Benefit: (including Chemical Dependency)	60%
▪ Outpatient Mental & Nervous Disorder Benefit: (including Chemical Dependency)	50%
▪ Outpatient Mental & Nervous Disorder Limits: (including Chemical Dependency)	25 visits per year $40 maximum charge per visit
▪ Outpatient Physical Therapy Benefit:	60%
▪ Outpatient Physical Therapy Limits:	20 visits per year $40 maximum charge per visit

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- Hospice Care: 60%
- Voluntary Family Planning: 60%

Exclusions: Usual policy exclusions plus, reverse sterilizations, fertility testing/treatment, private duty nursing, skilled nursing facility care, home health care, durable medical equipment, orthotic devices, spinal manipulation services, TMJ exclusion.

NOTES:

CARRIERS TO INCLUDE OWN COST CONTAINMENT / MANAGED CARE.

ORGAN TRANSPLANT BENEFIT DOES INCLUDE A BONE MARROW TRANSPLANT; LIMITED TO HUMAN-TO-HUMAN, NON-EXPERIMENTAL ORGAN TRANSPLANTS. CARRIER MAY COVER OTHER TYPES, I.E., ARTIFICIAL-TO-HUMAN, ANIMAL-TO-HUMAN OR EXPERIMENTAL, WITH THE COMMISSIONER'S APPROVAL.

PAP SMEARS AND MAMMOGRAMS ARE COVERED ~~UNDER THE WELLNESS BENEFIT AT 100% OF UCR~~TO THE EXTENT THE SERVICES ARE INCLUDED AS "PREVENTIVE HEALTH SERVICES" UNDER THE AFFORDABLE CARE ACT.

PRESCRIPTION DRUG BENEFIT DOES INCLUDE ORAL CONTRACEPTIVES REGARDLESS OF THE PRESCRIBED USE

VOLUNTARY FAMILY PLANNING IS LIMITED TO EXPENSES ASSOCIATED WITH TUBAL LIGATIONS AND VASECTOMIES

A CHILD SHALL CEASE TO BE ELIGIBLE FOR COVERAGE AS A DEPENDENT AT AGE ~~19~~26 PURSUANT TO THE REQUIREMENTS OF THE AFFORDABLE CARE ACT~~, OR IF A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL OR COLLEGE, AT AGE 25.~~ THIS DOES NOT APPLY TO A DEPENDENT CHILD WHO IS PHYSICALLY OR MENTALLY HANDICAPPED AND THEREFORE UNABLE TO SUPPORT THEMSELVES AND THE HANDICAP COMMENCED PRIOR TO THE DEPENDENT ATTAINING THE LIMITING AGE

NO BASIC HEALTH BENEFIT PLAN (INCLUDING GRANDFATHERED PLANS) SHALL IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION ON ANY ENROLLEE WHO IS UNDER 19 YEARS OF AGE, INCLUDING APPLICANTS FOR ENROLLMENT , FOR PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010.

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EVERY STANDARD AND BASIC HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER OCTOBER 9, 2008 SHALL COMPLY WITH NCGS 58-51-25(b) AS ADOPTED IN SECTION 17 OF SESSION LAW 2009-382 WHICH ADOPTS BY REFERENCE PUBLIC LAW 110-381, ALSO KNOWN AS "MICHELLE'S LAW".

~~AFTER AN INDIVIDUAL MEETS THE $100 WELLNESS BENEFIT IN A SINGLE BENEFIT PERIOD,~~ WELLNESS BENEFITS THAT ARE NOT INCLUDED AS

PREVENTIVE CARE UNDER THE AFFORDABLE CARE ACT ARE PAYABLE AT 60%, SUBJECT TO THE DEDUCTIBLE, COINSURANCE, AND OUT-OF-POCKET LIMIT

EVERY BASIC INDEMNITY HEALTH BENEFIT PLAN THAT IS ISSUED, RENEWED, OR AMENDED ON OR AFTER JULY 1, 1997 SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION RELATING TO PREGNANCY AS A PREEXISTING CONDITION

EVERY BASIC INDEMNITY HEALTH BENEFIT PLAN SHALL PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY IN ACCORDANCE WITH THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT WHICH WAS EFFECTIVE OCTOBER 21, 1998. THIS INCLUDES COMPLIANCE WITH THE NOTICE REQUIREMENTS.

EVERY BASIC HEALTH BENEFIT PLAN (OTHER THAN GRANDFATHERED PLANS) SHALL PROVIDE COVERAGE WITHOUT COST SHARING FOR PREVENTIVE HEALTH SERVICES AS REQUIRED UNDER THE AFFORDABLE CARE ACT.

AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, INSURERS SHALL NOT RESCIND COVERAGE UNDER A BASIC HEALTH BENEFIT PLAN (INCLUDING GRANDFATHERED PLANS) WITH RESPECT TO AN INDIVIDUAL (INCLUDING THE GROUP TO WHICH THE INDIVIDUAL BELONGS) ONCE THE INDIVIDUAL IS COVERED UNLESS THE INDIVIDUAL (OR A PERSON SEEKING COVERAGE ON BEHALF OF THE INDIVIDUAL) PERFOMS AN ACT, PRACTICE, OR OMMISSION THAT CONSTITUTES FRAUD, OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT.

AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, BASIC HEALTH BENEFIT PLANS (EXCEPT A GRANDFATHERED PLAN) SHALL PROVIDE PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE AS PROVIDED IN THE AFFORDABLE CARE ACT.

AS OF PLAN YEARS BEGINNING ON OR AFTER SEPTEMBER 23, 2010, BASIC HEALTH BENEFIT PLANS (OTHER THAN GRANDFATHERED PLANS) SHALL PROVIDE COVERAGE FOR EMERGENCY SERVICES AS PROVIDED UNDER THE AFFORDABLE CARE ACT *AND* IN ACCORDANCE WITH G.S. 58-3-190 TO THE EXTENT THAT THE STATE STATUTE IS MORE FAVORABLE TO INSURED MEMBERS THAN THE FEDERAL STANDARD.

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COVERED EXPENSES

Covered Expenses are those which can apply to meet the deductible amount or for which benefits can be paid. Covered expenses include the following charges for services or supplies ordered by a doctor for the medical care of injury or sickness. **All benefits are paid at 60% subject to the deductible unless the benefit summary indicates otherwise. Note that some limitations may apply.**

1. Charges made by hospitals for:

    a) Room and board and any nurse care but not more, for each day of hospital confinement, than the charges of the hospital for a two-bed room of its largest class of two-bed rooms;

    b) Confinement in an intensive care unit of the hospital but not more, for each day of confinement in an intensive care unit, than 300% of the charges of the hospital for a two-bed room of its largest class of two-bed rooms; and

    c) Other hospital services and supplies; and

2. If not included in 1. above, charges made by/for:

    a) Doctors, other than a doctor who normally lives in your home or who is a member of your immediate family, for medical or surgical care, including an assistant surgeon.

    b) Physical Therapist, other than physical therapist who normally lives in your home or who is a member of your immediate family, for Outpatient Physical Therapy

    c) Doctors or professional anesthetists for furnishing and giving anesthetics.

    d) Radiologists or Laboratories for diagnosis or treatment. Inpatient admissions which are primarily for diagnostic studies are not covered.

    e) Professional ambulance service for taking the patient to or from a hospital.

    f) Others for:

        i) Drugs or medicines that are ordered for the patient in writing by a doctor and dispensed by a licensed pharmacist or a doctor;

        ii) Blood or other fluids to be injected into the circulatory system.

        iii) Casts or Splints

        iv) Surgical dressings

        v) The first supply of the following prosthesis and medical supplies, artificial limbs or eyes, trusses, braces or crutches, however replacement of any such item is not covered.

vi) The first supply of an external breast prosthetic device that is prescribed after a mastectomy performed while the patient is insured; however, the replacement of such item is not covered.

vii) Oxygen and the purchase or rental, whichever is least expensive as determined by the insuring entity, of equipment to give it.

g) Maternity Care for insured employee/subscriber/member and the insured dependent spouse only (except complications of pregnancy are covered for all insureds). Includes inpatient care for a mother and her newly born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by cesarean section. Coverage shall include timely post-delivery care, if the physician, in consultation with the mother, discharges the mother and the newborn prior to the expiration of the minimum stays.

h) Treatment of Mental & Nervous Disorders and chemical dependency.

i) Organ Transplant limited to human-to-human, non-experimental organ transplants. Includes charges for:
i) initial testing and diagnosis;
ii) immunosuppressant drug therapy before and subsequent to the surgery, no matter how long after the surgery;
iii) complications resulting from surgery, organ rejection or failure, whether current or anticipated; and
iv) any repeat transplants of the same type of organ.

j) ~~Wellness Benefits including Pap Smears, Mammograms and other specified wellness benefits subject to limits as specified~~Preventive Health Services as provided under the Affordable Care Act. Other Wellness benefits not so included shall be covered subject to the deductible, co-insurance and out-of-pocket limits.

k) Hospice Care.

l) Voluntary Family Planning.

m) Coverage for reconstructive breast surgery in accordance with the federal Women's Health and Cancer Rights Act which was signed into law on October 21, 1998. This includes compliance with notice requirements.

SCHEDULE OF BENEFITS

SERVICES	**BENEFITS**
BENEFIT PERIOD:	Calendar year.
DEDUCTIBLE:	$1,000 per Benefit Period per Insured Deductible applies to all services except Wellness Benefits $50 per emergency room visit per Insured $50 Deductible per emergency room visit – waived if the Insured is admitted to the Hospital
FAMILY DEDUCTIBLE	No more than 3 Insureds under one Family Coverage must satisfy their Deductible in each Benefit Period
OUT-OF-POCKET LIMIT	$3,000 per Benefit Period per Insured. After reaching the Out-of-Pocket Limit, the benefits payable for that Insured during the remainder of the Benefit Period will increase from 60% to 100% of the UCR The Out-of-Pocket Limit will not include any amount applied to the Deductible The Out-of-Pocket Limit will not include any expense disallowed for services which are received contrary to any provisions of the policy Outpatient Mental & Nervous Disorder Services, Chemical Dependency Treatment and Physical Therapy Services will not apply to the Out-of-Pocket Limit

MAXIMUMS Insured (refer to endnote #1)	$~~100,000~~750,000 per Benefit Period per for all Covered Services, including Covered Services with specific maximum benefits
~~$1,000,000 per Lifetime per Insured for all Covered Services, including Covered Services with specific maximum benefits~~	
~~$10,000 per Lifetime per Insured for Mental & Nervous Disorder and Chemical Dependency Benefits~~	
~~$100,000 per Lifetime per Insured per Organ for Organ Transplants~~	

The following benefits are payable at 60% of Provider's Reasonable Charge except as noted otherwise:

- HOSPITAL SERVICES
  - Inpatient and Outpatient Services
  - Emergency Care
- SURGICAL SERVICES
  - Surgeon and Assistant Surgeon
  - Anesthesia
- MEDICAL CARE
  - Inpatient Medical Care Services
  - Outpatient Medical Care Services including:
    - Outpatient Diagnostic Services

- Outpatient Physical Therapy: $40 maximum charge per visit
  20 Physical Therapy visits per Benefit Period per Insured

- Outpatient Physical Therapy Benefit: 60%

➢ Maternity Care Services: As any other illness; for insured employee/ subscriber/member & the insured dependent spouse only, including inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by cesarean section, and timely post-delivery care for the mother and the newly born child if the physician, in consultation with the mother, discharges the mother and the newly born child prior to the expiration of the minimum stays.

➢ Mental & Nervous Disorders Treatment including Chemical Dependency

- Outpatient Limits: $40 maximum charge per visit
  25 Outpatient visits per Benefit Period per Insured

- Outpatient Mental & Nervous Disorder and Chemical Dependency Treatment Benefit: 50%

- Inpatient Mental & Nervous Disorder and Chemical Dependency Treatment Benefit: 60%

➢ Organ Transplant Benefit: ~~$100,000 per Organ per Lifetime per Insured~~

includes bone marrow transplant; limited to human-to-human, non-experimental organ transplants; carriers can cover other types, i.e., artificial-to-human, animal-to-human or experimental with the permission of the Commissioner

➢ Hospice Care	A coordinated program for meeting the special physical; (b) psychological; (c) spiritual; and (d) social needs of dying individuals and their families. Providing palliative and supportive medical, nursing and other health services through home or inpatient care during the illness to i) persons who have no reasonable prospect of cure and, as estimated by a doctor, have a life expectancy of 6 months or less; and ii) the families of those persons
~~➢ Wellness Benefits:~~	~~First $100 per Benefit Period per insured is not subject to the deductible; then subject to deductible and coinsurance~~
➢ Preventive Health Services as required under the Affordable Care Act	100%
➢ Wellness Benefits for those services not included as Preventive Services under the Affordable Care Act	60%
➢ Ambulance Service	
➢ Prescription Drug	
➢ Medical Supplies and Prosthetic Appliances	
➢ Voluntary Family Planning	

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EXCLUSIONS

Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a Provider.

2. Which are not Medically Necessary;

3. Rendered by other than a Hospital or a Provider;

4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;

5. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid 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.

6. To the extent benefits are provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service related medical conditions.

7. For any illness or injury suffered as a result of any act of war or while in military service;

8. For which an Insured would have no legal obligation to pay in the absence of this or any similar coverage;

9. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

10. Surgery and any related services intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies, except as required for reconstructive breast surgery in accordance with the federal Women's Health and Cancer Rights Act;

11. Rendered by a Provider who is a member of the Insured's immediate family;

12. Incurred prior to the Insured's Effective Date or during an inpatient admission that commenced prior to the Insured's effective date of coverage;

13. Incurred after the date of termination of the Insured's coverage;

14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

15. For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of any form or charges for medical information;

16. For inpatient admissions which are primarily for diagnostic studies;

17. For the care of a pre-existing condition, except in the case of a late-enrollee, for not more than 12 months; however, the plan shall provide credit for creditable coverage in accordance with NCGS 58-68-30(a)(3). Children under age 19 shall not be subject to any pre-existing condition exclusion as provided in the Affordable Care Act.

18. For custodial care, domiciliary care or rest cures;

19. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;

20. For screening examinations including x-ray examinations made without film; except those provided under the ~~wellness benefits~~preventive health services as provided under the Affordable Care Act.

21. For sterilization and reversal of sterilization for dependent children;

22. For reverse sterilization;

23. For dental work or treatment which includes hospital or professional care in connection with: an operation or treatment for the fitting or wearing of dentures; orthodontic care or treatment of malocclusion; and operations on or treatment of or to the teeth or supporting tissues of the teeth except for: removal of malignant tumors and cysts; or treatment of an injury to natural teeth due to an accident (other than an accident occurring while, and as a result of eating or chewing), if the accident occurs while the patient is insured and the treatment is received within twelve months after the accident;

24. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns. calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;

25. For eye glasses or contact lenses and the vision examination for prescribing or fitting eye glasses or contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury), except to the extent that such services/items are included as "preventive health services" under the Affordable Care Act;

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~~27.~~26. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;

~~28.~~27. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, except to the extent that such services/items are included as "preventive health services" under the Affordable Care Act ;

~~29.~~28. For inpatient admissions which are primarily for physical therapy;

~~30.~~29. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery;

~~31.~~30. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of an Insured, except to the extent that such services/items are included as "preventive health services" under the Affordable Care Act, ;

~~32.~~31. For treatment of obesity; , except to the extent that such services/items are included as "preventive health services" under the Affordable Care Act,

~~33.~~32. For treatment of sexual dysfunction not related to organic disease;

~~34.~~33. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for inpatient confinement for environmental change;

~~35.~~34. For services and supplies for or related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

~~36.~~35. For travel whether or not recommended by a physician;

~~37.~~36. For complications or side-effects arising from services, procedures, or treatments excluded by this policy;

~~38.~~37. For the correction of, or complications arising from, treatment or an operation to improve appearance if the original treatment or operation either was not a Covered Expense under this policy or would not have been a Covered Expense if the patient had been insured;

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~~39.~~38. For cosmetic purposes including restoration of hair and appearance of skin;

~~40.~~39. For maternity care for dependent children; unless the care is due to complications of pregnancy.

~~41.~~40. For any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law.

~~42.~~41. For private duty nursing;

~~43.~~42. For skilled nursing facility care;

~~44.~~43. For or related to organ transplants (except those Organ Transplants specifically listed as Covered Expenses, and then only for those diagnoses listed, if so limited); for or related to transplantation of animal or artificial organs or tissues.

~~45.~~44. For home health care;

~~46.~~45. For Durable Medical Equipment;

~~47.~~46. For the care or treatment of an injury that is intentionally self-inflicted, while sane or insane, unless otherwise required to be covered by Federal law;

Federal law requires that if a group plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for the treatment of the injury because of the manner by which the injury is incurred if the injury is attributed to an underlying medical condition (including both physical and mental health conditions) or the injury is attributed to an act of domestic violence.

~~48.~~47. For the care or treatment of an injury due to the commission of, or an attempt to commit, an assault or a felony or an injury or sickness incurred while engaging in an illegal act or occupation;

~~49.~~48. For lifestyle improvements, including smoking cessation, nutrition counseling or physical fitness programs , except to the extent that such services are included as "preventive health services" under the Affordable Care Act;

~~50.~~49. For wigs or cranial prosthesis;

~~51.~~50. For confinement treatment or services covered by medical expense insurance covered under the individual purchase rights (and conversions) described in this policy;

~~52.~~51. For weekend admission charges, except for emergencies and maternity;

~~53.~~52. For the care or treatment of an injury or sickness due to voluntary participation in a riot;

~~54.~~53. For orthomolecular therapy including nutrients, vitamins and food supplements;

~~55.~~54. For speech therapy, except to restore speech abilities which were lost due to injury or sickness;

~~56.~~55. For the treatment of Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Pain Syndrome (CPS), except surgical services for TMJ and CPS are covered, but only if medically necessary and there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;

~~57.~~56. For services rendered by a physician for the detection (including the cost of x-ray and/or laboratory services) and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

[i] Annual Limits on essential benefits are limited to:
$750,000 for plans years beginning with 9/23/2010 - 9/22/2011;
$1.25 Million for plan years beginning 9/23/2011 – 9/22/2012
$2 Million for plan years beginning 9/23-2012 – 12/31/2013

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