NORTH CAROLINA SMALL EMPLOYER GROUP
STANDARD INDEMNITY PLAN

SUMMARY OF BENEFITS

Calendar Year Deductible:	$500 [1]
Emergency Room Deductible:	$50 per visit, waived when admitted
Carryover Deductible:	None
Family Deductible Limit:	3 Family Members
Out-of-Pocket Limit:	$2,000 per Insured per year (plus a $500 deductible)
Family Out-of-Pocket Limit:	$4,000
~~Lifetime Maximum:~~	~~$1,000,000 per Insured~~
Benefit Percentage:	80% (unless noted otherwise)
~~Wellness Benefit~~Preventive Health Services as required under the Affordable Care Act:	~~$100 per benefit period per insured not subject to deductible~~100%
Wellness Benefit not included as a Preventive Services as required under the Affordable Care Act	80%
Maternity:	Insured Employee and Insured Dependent Spouse only; paid as any illness; Doctors' Charges for the First Pre-Natal Visit if the Visit is Within the First Three Months After the Pregnancy Begins are Paid at 100%
Daily Room & Board:	Semi-Private based upon the largest class of semi-private rooms of the hospital
Intensive Care Room & Board Limit:	3 times Semi-Private
Daily Extended Care Limit:	One-Half of the Semi-Private rate of the hospital where confined prior and limited to 100 days of care in any 12 consecutive month period
Mental Health Inpatient and Outpatient Benefit	80%
Mental Health Inpatient/Outpatient Durational Limits [2]	30 combined inpatient and outpatient days per year
Mental Health Office Visit Benefit	80%
Mental Health Office Visit Durational Limits [3]	30 office visits per year
~~Lifetime Chemical Dependency Maximum~~	~~$10,000 per Insured~~
Inpatient Chemical Dependency Benefit	80%
Outpatient Chemical Dependency Benefit	50%

Outpatient Chemical Dependency Limits	25 visits per year /$60 maximum charge per visit
Outpatient Physical Therapy Benefit	50%
Outpatient Physical Therapy Limits:	20 visits per year/ $40 maximum charge per visit
Outpatient Chiropractic Benefit:	50%
Outpatient Chiropractic Limits:	35 visits per year/ $40 maximum charge per visit
~~Organ Transplant Limitation:~~	~~$100,000 per organ per insured~~
Prescription Drugs:	80%
Hospice Care:	80%
Voluntary Family Planning:	80%

Exclusions: Usual policy exclusions plus: reverse sterilizations, preconception or genetic testing, fertility treatments, experimental drugs or treatments, TMJ exclusion

NOTES:

CARRIERS TO INCLUDE OWN COST CONTAINMENT/MANAGED CARE;

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.

ORGAN TRANSPLANTS 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.

ALL PLANS ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 1994 MUST INCLUDE COVERAGE, UNDER THE WELLNESS BENEFIT, FOR THE PROSTATE-SPECIFIC ANTIGEN (PSA) TEST OR EQUIVALENT TESTS WHEN RECOMMENDED BY A PHYSICIAN. COST SHARING MAY APPLY.

DRUGS WHICH ARE APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) FOR THE TREATMENT OF CERTAIN TYPES OF CANCER SHALL NOT BE EXCLUDED ON THE BASIS THAT THE DRUG HAD BEEN PRESCRIBED FOR THE TREATMENT OF A CERTAIN TYPE OF CANCER FOR WHICH THE DRUG HAD NOT BEEN APPROVED BY THE FDA. REFER TO AMENDMENTS ADOPTED IN SESSION LAW 2009-170 RELATED TO THE COMPENDIA.

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

~~AFTER ANY INDIVIDUAL MEETS THE $100 WELLNESS BENEFIT IN A SINGLE BENEFIT PERIOD,~~ WELLNESS BENEFITS NOT INCLUDED AS PREVENTIVE SERVICE UNDER THE AFFORDABLE CARE ACT ARE PAYABLE AT 80%, SUBJECT TO THE DEDUCTIBLE, COINSURANCE, AND OUT-OF-POCKET LIMIT.

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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 STANDARD 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.

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".

EVERY STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 1998 SHALL PROVIDE COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY RESULTING FROM A MASTECTOMY. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-51-62, INCLUDING THE NOTIFICATION REQUIREMENTS.

EVERY STANDARD 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 STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR A QUALIFIED INDIVIDUAL FOR SCIENTIFICALLY PROVEN BONE MASS MEASUREMENT FOR THE DIAGNOSIS AND EVALUATION OF OSTEOPOROSIS OR LOW BONE MASS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-174 AND SHALL BE PROVIDED WITHOUT ANY COST SHARING AS PROVIDED UNDER THE AFFORDABLE CARE ACT.

EVERY STANDARD INDEMNITY HEALTH BENEFIT PLAN THAT IS IN FORCE, ISSUED, RENEWED, OR AMENDED ON OR AFTER JANUARY 1, 2000 SHALL PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES THAT PREVENT PREGNANCY. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-176.

EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2000 THAT ISSUES A PRESCRIPTION DRUG CARD, SHALL ISSUE TO ITS INSUREDS A UNIFORM PRESCRIPTION DRUG CARD PURSUANT TO NCGS 58-3-177 AS ADOPTED IN SENATE BILL 513.

EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2002 SHALL PROVIDE COVERAGE FOR COLORECTAL CANCER EXAMINATIONS AND LABORATORY TESTS. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-179 AND SHALL BE PROVIDED WITHOUT ANY COST SHARING AS PROVIDED UNDER THE AFFORDABLE CARE ACT.

EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JANUARY 1, 2004 SHALL PROVIDE COVERAGE FOR SURVEILLANCE TESTS FOR OVARIAN CANCER. THIS COVERAGE SHALL BE AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-270.

EVERY STANDARD HEALTH BENEFIT PLAN THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED ON OR AFTER JULY 1, 2008 SHALL PROVIDE COVERAGE FOR TREATMENT OF MENTAL ILLNESS THAT IS AT LEAST EQUAL TO THE COVERAGE REQUIRED BY NCGS 58-3-220.

EVERY STANDARD 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 STANDARD 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, STANDARD 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.

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 80% 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 for each day of hospital confinement, but not more 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 for each day of confinement in an intensive care unit, but not more 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 :

   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) Registered Nurses, other than a nurse who normally lives in your home or who is a member of your immediate family, for Private Duty Nursing Care.

   c) 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.

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

   e) Radiologists or Laboratories for diagnosis or treatment.

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

   g) 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 prosthetic appliances and medical supplies, artificial limbs or eyes, trusses, braces or crutches; however replacement 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.

viii) The purchase or rental, whichever is lease expensive as determined by the insuring entity, of a wheel chair, a hospital type bed, or mechanical equipment to treat respiratory paralysis.

h) Extended Care Facility for charges for room and board and skilled nursing care limited to a rate of one-half of the semi-private rate of the hospital where confined prior. No more than 100 days of confinement in twelve consecutive months will be covered. Confinement must commence within 14 days of a hospital stay of at least 3 days which was payable under the plan and the term of care in the extended care facility is continuous. A doctor must certify the care is required due to a need for skilled nurse care. The care of the patient must be supervised by a doctor at all times. This does not include confinements that are custodial.

i) 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.

j) Treatment of Mental and Nervous Disorders and chemical dependency. Mental health benefits shall be provided in compliance with NCGS 58-3-220.

k) 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.

l) ~~Wellness Benefits including Pap Smears, Mammograms, Prostate Specific Antigen Test and other specified wellness benefits subject to limits as specified.~~Preventive health services as provided under the Affordable Care Act.

~~l)~~m) Wellness Benefit for services not consider Preventive Care under the Affordable Care Act.

~~m)~~n) Outpatient Chiropractic Care

~~n)~~o) Hospice Care

~~o)~~p) Voluntary Family Planning

~~p)~~q) Reconstructive breast surgery resulting from a mastectomy due to breast cancer or breast disease. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Subject to the approval of the treating physician, reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction. Coverage must be at least equal to the requirements of NCGS 58-51-62, including the notification requirements.

~~q)~~r) Scientifically proven bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass for qualified individuals. Coverage must be at least equal to the coverage required by NCGS 58-3-174 and shall be provided without cost sharing.

~~r)~~s) Prescribed contraceptive drugs and devices to prevent pregnancy. Coverage must be at least equal to the coverage required by NCGS 58-3-176.

~~s)~~t) Colorectal cancer examinations and laboratory tests. Coverage must be at least equal to the coverage required by NCGS 58-3-179 and shall be provided without cost sharing.~~.~~

~~t)~~u) Surveillance tests for women age 25 and older as risk for ovarian cancer. Coverage must be at least equal to the coverage required by NCGS 58-3-270.

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SCHEDULE OF BENEFITS

SERVICES **BENEFITS**

SERVICES	OUT-OF-NETWORK BENEFITS
BENEFIT PERIOD	CALENDAR YEAR
BENEFIT PAYABLE	80%
INDIVIDUAL DEDUCTIBLE	$500
FAMILY DEDUCTIBLE	3 X INDIVIDUAL
INDIVIDUAL OUT-OF-POCKET LIMIT	$2,000
FAMILY OUT-OF-POCKET LIMIT	2 X INDIVIDUAL
BENEFIT PAYABLE AFTER OUT-OF-POCKET LIMIT IS MET	100%
EMERGENCY ROOM DEDUCTIBLE	$50 PER USE, WAIVED IF ADMITTED

THE FOLLOWING APPLY TO THE BENEFITS OF THIS PLAN

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 Chemical Dependency Treatment, Outpatient Chiropractic Services, and Physical Therapy Services will not apply to the Out-of-Pocket Limit

~~MAXIMUMS: $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 Chemical Dependency Benefits~~

~~$10,000 per Lifetime per Insured for Outpatient Private Duty Nursing (Limited to $2,500 per Benefit Period)~~

~~$100,000 per Lifetime per Insured per Organ for Organ Transplants~~

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The following benefits are paid at 80% of Provider's Reasonable Charge unless noted otherwise. Covered Expenses Section for further clarification.

- HOSPITAL SERVICES:
  - Inpatient and Outpatient Services
  - Emergency Care
- SURGICAL SERVICES:
  - Surgeon and Assistant Surgeon
  - Anesthesia
- MEDICAL CARE:
  - Inpatient Medical Care Services
  - Outpatient Medical Care Service including:
    - Outpatient Prescription Drugs
    - Outpatient Diagnostic Services
    - Outpatient Physical Therapy: $40 maximum charge per visit
20 Physical Therapy visits per Benefit Period per Insured.
    - Outpatient Physical Therapy Benefit: 50%
  - 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; doctor's charges for first prenatal visit are paid at 100% if the visit is within three months after the pregnancy begins

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➢ Mental Health Benefit	80%
▪ Combined Inpatient and Outpatient Visits Limits[4]	30 days per year
▪ Office Visits Limits [5]	30 visits per year
➢ Chemical Dependency Treatment	
▪ Outpatient Limits:	$60 maximum charge per visit 25 Outpatient visits per Benefit Period per Insured
▪ Outpatient Chemical Dependency Treatment Benefit:	50%
▪ Inpatient Chemical Dependency Treatment Benefit:	80%
➢ Chiropractic Care Services	
▪ Outpatient Limits:	$40 maximum charge per visit 35 Outpatient visits per Benefit Period per Insured
▪ Outpatient Chiropractic Benefit:	50%
➢ Organ Transplant Services:	~~$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, experimental with the permission of the Commissioner
➢ Hospice Care	A coordinated program for meeting the special: (a) 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 persons who have no reasonable prospect of cure and, as estimated by a doctor, have a life

expectancy of 6 months or less; and the families of those persons

- Ambulance Service
- Medical Supplies and Prosthetic Appliances
- Voluntary Family Planning
- Wellness Benefits 80%
  For those not consider Preventive Services under the Affordable Care Act
- Preventive Health Services 100%
  as required under the Affordable Care Act

~~- Wellness Benefits: First $100 per benefit period per insured is not subject to the deductible; then subject to deductible and coinsurance~~

~~- Well Child Care and Immunization: 100% of UCR; if individual has used the $100 Wellness Benefit during a benefit period, then immunizations administered to that individual during the remainder of that benefit period shall be paid at 80% subject to deductible and out-of-pocket limit~~

~~- Routine Physical Examinations: 100% of UCR~~

~~- Benefits are limited to: general health checkups, x-rays, blood pressure checks, urine tests, tuberculosis tests, routine diagnostic tests, colon exams, prostate exams and rectal exams~~

~~- Benefits for routine diagnostic procedures are limited to:~~
~~♦ once every 3 years for Insureds from 19 to 39 years of age~~
~~♦ once every 2 years for Insureds from 40 to 55 years of age~~
~~♦ once every year for Insureds 56 years of age and older.~~

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~~SCHEDULE OF BENEFITS~~
~~(CONTINUED)~~

- ~~Pap Smears :~~ ~~Limit of 1 per Benefit period per Insured, unless recommended more often by a Provider.~~

- ~~Mammography:~~
  - ~~One or more mammograms per year, for female insureds, as recommended by a provider for any woman at risk of breast cancer~~
  - ~~A single mammogram for any woman age 35 through 39~~
  - ~~A mammogram every other year for any woman age 40 through 49~~
  - ~~A mammogram every year for any woman age 50 or older~~
  - ~~Or more frequently as a Provider recommends~~

- ~~PSA Tests~~ ~~As recommended by a physician~~

EXCLUSIONS

Benefits will not be paid for charges:

1. For, or in connection with, the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;

2. For medical services or supplies if no charge would have been made if the patient did not have this insurance;

3. 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."

4. 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;

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

6. For custodial or sanitarium care or rest cures;

7. 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;

8. For treatment with new drugs or technological medical devices which are experimental in nature;

9. For testing eyesight or purchase or fitting to glasses, contact lenses (except following cataract surgery), hearing aids, corrective shoes, or other corrective devices or appliances, except to the extent the service/device is consider a "preventive health service" under the Affordable Care Act;

10. For exams or tests for check-up purposes that are not for the treatment of injury or sickness; except as otherwise noted and as provided under the Affordable Care Act for "preventive health services".

11. For treatment or surgery for obesity, weight reduction or weight control, except to the extent the service/device is consider a "preventive health service" under the Affordable Care Act;

12. For orthomolecular therapy including nutrients, vitamins and food supplements;

13. 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;

14. 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;

15. 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;

16. For lifestyle improvements, including smoking cessation, nutrition counseling or physical fitness programs except to the extent the service/device is consider a "preventive health service" under the Affordable Care Act;

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

18. 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 the Group Policy or would not have been a Covered Expense if the patient had been insured; except as required for reconstructive breast surgery in accordance with NCGS 58-50-155(a2) and NCGS 58-51-61.

19. In connection with 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). This exclusion will not apply to a pregnancy, which shall never be considered a preexisting condition. Children under age 19 shall not be subject to any pre-existing condition exclusion, as provided in the Affordable Care Act.

20. Due to the pregnancy of a dependent child. This exclusion will not apply to medical care due to complications of pregnancy;

21. 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;

22. For pre-conception testing or genetic testing; for artificial insemination or an implant procedure to induce pregnancy; for in vitro fertilization; for a procedure to reverse a surgically performed sterilization; or for a sex change;

23. For treatment that is not medically necessary for the care of an injury or sickness except as specifically noted in the ~~Wellness Benefit~~preventive health services as required under the Affordable Care Act;

24. To the extent that they are more than either: (a) the customary charge made by the provider for the treatment furnished; or (b) the general level of charges made by others in the same locality for such treatment. If the amount of the customary charges or the general level of charges for a service cannot be determined due to the unusual nature of the service, XYZ will determine the amount XYZ will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors;

25. For surgery and any related services intended to solely improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies;

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

27. For organ transplants which are considered experimental, related to transplantation of animal organ or tissues, or related to transplantation of artificial organs or tissues;

28. For weekend admission charges, except for emergencies and maternity care;

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

30. For the treatment of Temporomandibular Joint Dysfunction (TMJ) or 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;

[1] Applies to Mental health benefits too

[2] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

[3] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

[4] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.

[5] Except when services are provided for Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Paranoid and Other Psychotic Disorder, Schizoaffective Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anorexia Nervosa, and Bulimia, which shall not be subject to any durational limitations.