Benefit Booklet
For Employees of
UW Small HSA
for

Blue OPTIONS HSA℠

Benefit Booklet

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet, along with the GROUP CONTRACT, is the legal contract between your EMPLOYER and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified SUBSCRIBERS and eligible DEPENDENTS who are listed on the Group Enrollment Application and who are accepted in accordance with the provisions of the GROUP CONTRACT entered into between Blue Cross and Blue Shield of North Carolina and the SUBSCRIBER'S EMPLOYER. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

Blue Cross and Blue Shield of North Carolina has directed that this Benefit Booklet be issued and signed by the President and the Secretary.

Attest:

President

Secretary

Important Cancellation Information - Please Read The Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."

PRE-EXISTING CONDITION Limitations May Apply To Your Coverage. Please Read This Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."

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RECENT CHANGES

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in this benefit booklet, and are effective at the start of your BENEFIT PERIOD (see "Summary Of Benefits") unless otherwise noted.

PRESCRIPTION DRUG Changes:

Starting April 1, 2012, BCBSNC is changing our pharmacy benefits management vendor to Prime Therapeutics. As a result, the following changes are being made:

- New claim address (effective April 1, 2012):
  If you need to file a PRESCRIPTION DRUG claim, send it to:
  Mail Route: BCBSNC
  P.O. Box 14501
  Lexington, KY 40512-4501

- Where to go to receive an extended supply (greater than 30- day supply and up to a 90-day supply) of your PRESCRIPTION DRUGS (effective July 1, 2012):
  If you need to receive an extended supply of your PRESCRIPTION DRUGS, visit **bcbsnc.com** for a listing of retail pharmacies that can dispense an extended supply of your prescription. You can also receive up to a 90-day supply of the PRESCRIPTION DRUGS that you take on a regular basis through a mail-order service. This information is also on the same website.

Please note that your PRESCRIPTION DRUG benefits are not changing as a result of the new pharmacy vendor. If you have any questions, you can call BCBSNC Customer Service at the number on the back of your ID CARD.

The process to obtain certain restricted access drugs and devices has been modified as follows (effective April 1, 2012):

For certain PRESCRIPTION DRUGS to be covered, BCBSNC may require that the MEMBER has tried one or more preferred drugs or devices. Coverage for these restricted access drugs or devices may be provided without the use of the preferred drug(s) or device(s) if the PROVIDER certifies in writing that the MEMBER has previously used the preferred drug(s) or device(s) and the preferred drug(s) or device(s) have been detrimental to the MEMBER'S health or have been ineffective in treating the same condition and, in the opinion of the PROVIDER, are likely to be detrimental to the MEMBER'S health or ineffective in treating the condition in the future.

Revisions To Your Benefits Due To Clarifications Of The Federal Mental Health Parity Law

Due to federal legislation clarifications concerning mental health and substance abuse services, the procedure for requesting PRIOR REVIEW and obtaining CERTIFICATION for these services has changed. Throughout your benefit booklet, references to PRIOR REVIEW and CERTIFICATION for mental health and substance abuse services are affected by this change. The section below called "How To Access Mental Health And Substance Abuse Services" explains the revised procedure for requesting PRIOR REVIEW. Please refer to this revised section to determine the CERTIFICATION requirements for your mental health and substance abuse benefits.

Please see your "Summary Of Benefits" for the following change(s):

- CERTIFICATION Requirements

The following limitation in your **PRESCRIPTION DRUGS** section is deleted:

- The benefit for any PRESCRIPTION DRUG used for the purpose of smoking cessation is limited to one course of treatment per 365 days and two courses of treatment per lifetime.

The section in your booklet, entitled "Mental Health And Substance Abuse Services," is amended by deleting this section in its entirety and replacing it with the following:

Mental Health And Substance Abuse Services

Your health benefit plan provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or OTHER PROVIDER. Your coverage for IN-NETWORK inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. BCBSNC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. To understand more about when you need to contact Magellan Behavioral Health, see "How To Access Mental Health And Substance Abuse Services."

OFFICE VISIT Services

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- MEDICALLY NECESSARY biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under OFFICE VISIT services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Certain outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. Call Magellan Behavioral Health at the number listed in "Whom Do I Contact?" for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

Inpatient Services

Covered inpatient services also include:

- Each service listed in this section under OFFICE VISIT services
- Semi-private room and board
- Detoxification to treat substance abuse.

How To Access Mental Health And Substance Abuse Services

PRIOR REVIEW by Magellan Behavioral Health is not required for OFFICE VISIT services. Although PRIOR REVIEW is not required for EMERGENCY situations, please notify Magellan Behavioral Health of your inpatient admission as soon as reasonably possible.

When you need inpatient or outpatient services that require PRIOR REVIEW and CERTIFICATION, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Contact?" The Magellan Behavioral Health customer service representative can also help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Counseling with relatives about a patient
- Inpatient confinements that are primarily intended as a change of environment.

Revisions To Your Benefits Due To Changes In State Law

Hearing Aids

The following hearing aid benefit for members under age 22 is added to your health benefit plan:
Your health benefit plan now provides coverage for MEDICALLY NECESSARY hearing aids and related services that are ordered by a DOCTOR or a licensed audiologist for each member under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER'S needs. This benefit is limited to once every 36 months. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

Lymphedema-Related Services

The section in your booklet titled "Lymphedema-Related Services" is deleted in its entirety and replaced with the following:

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice. Benefits include MEDICALLY NECESSARY equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only with a PRESCRIPTION and when custom-fit for the patient.

Lymphedema-Related Services Exclusions

- Over-the-counter compression or elastic knee-high or other stocking products.

Revisions To Your Benefits Due To Changes In Federal Law

Due to recent passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reform Act (HCERA), several of your benefits or eligibility criteria have changed. Please refer to the sections listed below to understand how these changes affect your coverage.

Office Services

Nutritional counseling visits are now considered a part of your PREVENTIVE CARE benefit, and are covered IN-NETWORK (100%) and OUT-OF-NETWORK (70% after deductible) when received in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center. Also, any visit limits no longer apply.

As a result of this change, the following language is deleted in its entirety from the "Office Services" section:

"Your health benefit plan also provides benefits for a total of six nutritional counseling visits per BENEFIT PERIOD to an IN- or OUT-OF-NETWORK PROVIDER for those MEMBERS who participate in BCBSNC's Member Health Partnerships℠ program. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight."

PREVENTIVE CARE

The section in your book titled "PREVENTIVE CARE" is deleted in its entirety and replaced with the following:

Your health benefit plan covers PREVENTIVE CARE services that can help you stay safe and healthy. When you receive covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center, there is no cost to you. Please note, this benefit is only for services that indicate a diagnosis of preventive or wellness. Otherwise, services will be subject to your IN-NETWORK benefit level for the location where services are received.

Please log on to our Web site at **bcbsnc.com/preventive** or call Customer Service at the number in "Whom Do I Contact" for the most up-to-date information on PREVENTIVE CARE that is covered under your health benefit plan, including certain over-the-counter medications that may be available. These over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

PREVENTIVE CARE COVERED SERVICES include:

Routine Physical Examinations And Screenings

Routine physical examinations and related diagnostic services and screenings are covered for MEMBERS as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF). Preventive care and screenings for women as recommended by the Health Resources and Services Administration (HRSA) are also covered.

Well-Baby And Well-Child Care

These services are covered for each MEMBER including periodic assessments and immunizations as recommended by the Health Resources and Services Administration (HRSA).

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered.

Immunizations Exclusion

- Immunizations required for occupational hazard or international travel, unless specifically covered by your health benefit plan.

Routine Eye Exams

Your health benefit plan provides coverage for one routine comprehensive eye examination per BENEFIT PERIOD. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of your health benefit plan.

Routine Eye Exams Exclusions

- Fitting for contact lenses, glasses or other hardware.
- Diagnostic services that are not a component of a routine vision examination.

Bone Mass Measurement Services

Your health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Qualified individuals include MEMBERS who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Newborn Hearing Screening

Coverage is provided for newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss.

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma- virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female MEMBERS age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female MEMBER is considered “at risk” if she:

- has 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
- tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Your health benefit plan provides coverage for one baseline mammogram for any female MEMBER between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female MEMBER per calendar year, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic MEMBER who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings.

> The PROVIDER search on our Web site at **bcbsnc.com** can help you find office-based PROVIDERS or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per calendar year. Additional PSA tests will be covered if recommended by a DOCTOR.

PRESCRIPTION DRUG Benefits

The bullet point in your booklet that describes coverage for over-the-counter medications is revised to read:

- Certain over-the-counter drugs when listed as covered in the FORMULARY, or under your PREVENTIVE CARE benefit, and a PROVIDER'S PRESCRIPTION for that drug is presented at the pharmacy

Adding Or Removing A DEPENDENT

The third paragraph of the section titled "Adding Or Removing A DEPENDENT" is revised to read:

You may remove DEPENDENTS from your coverage by contacting your GROUP ADMINISTRATOR and completing the proper form. DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, or when a spouse is no longer eligible due to divorce or death.

Termination Of MEMBER Coverage

The fourth bullet point under the section titled "Termination for Cause" is revised to read:

- Fraud or intentional misrepresentation of a material fact by a MEMBER or DEPENDENT. However, if such termination is made retroactively to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see "What If You Disagree

With Our Decision?" If your policy is rescinded, any premiums paid will be returned unless BCBSNC deducts the amount for any claims paid.

UTILIZATION MANAGEMENT

The section titled "UTILIZATION MANAGEMENT" is deleted in its entirety and replaced with the following:

To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under your health benefit plan unless the CERTIFICATION was based on a material misrepresentation about your health condition or you are not eligible for these services under your health benefit plan due to termination of coverage (including your voluntary termination of coverage) or nonpayment of premiums.

Rights And Responsibilities Under The UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's ADVERSE BENEFIT DETERMINATION of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a final determination of all ADVERSE BENEFIT DETERMINATIONS that were based upon MEDICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through our appeals process (see "What If You Disagree With Our Decision?")
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

  An authorized representative may act on the member's behalf with the member's written consent. In the event you appoint an authorized representative, references to "you" under the "Utilization Management" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a health care service is needed.
- Limit what we request from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with applicable state and federal law and your health benefit plan.

In the event that BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you of an ADVERSE BENEFIT DETERMINATION in writing. The notice will explain how you may appeal the ADVERSE BENEFIT DETERMINATION.

PRIOR REVIEW (Pre-Service)

BCBSNC requires that certain health care services receive PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION. The list of services that require PRIOR REVIEW may change from time to time.

General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for a detailed list of these services.

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your PROVIDER of how to properly complete your request. BCBSNC will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will notify you and the PROVIDER of an ADVERSE BENEFIT DETERMINATION electronically or in writing.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT'S life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your PROVIDER of its decision within 24 hours after receiving the request. If BCBSNC needs more information to process your expedited review, BCBSNC will notify you and your PROVIDER of the information needed as soon as possible but no later than 24 hours after we receive your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours.

An expedited review may be requested by calling BCBSNC Customer Service at the number given in "Whom Do I Contact?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the HOSPITAL or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you, your HOSPITAL'S or other facility's UM department and your PROVIDER. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT'S life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your PROVIDER of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews (Post-Service)

BCBSNC also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to determine if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this health benefit plan. If more information is needed, before the end of the initial 30-day period, BCBSNC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services.

Care management (or case management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and BCBSNC to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. BCBSNC is not obligated to provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for an ongoing special condition at the IN-NETWORK benefit level when you or your EMPLOYER changes health benefit plans or when your PROVIDER is no longer in the Blue Options network. If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition that meets our continuity of care criteria, BCBSNC will notify you 30 days before the PROVIDER'S termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, you must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by BCBSNC'S requirements for continuity of care.

An 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, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the MEMBER'S life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the PROVIDER, except in the cases of:

- scheduled SURGERY, organ transplantation, or inpatient care which shall extend through the date of discharge and post-discharge follow-up care or other inpatient care occurring within 90 days of the date of discharge; and

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be subject to your IN-NETWORK benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be provided when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

BCBSNC delegates UM and the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Claims determinations and second level appeal are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow us to determine the best services and products to offer our MEMBERS. They also help us keep pace with the ever-advancing medical field. Before implementing any new or revised policies, we review professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. We then seek additional input from PROVIDERS who know the needs of the patients they serve.

What If You Disagree With Our Decision?

The section titled "What If You Disagree With Our Decision?" is deleted in its entirety and replaced with the following:

In addition to the UM program, BCBSNC offers an appeals process for our MEMBERS.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your PROVIDER of the decision. The type of ADVERSE BENEFIT DETERMINATION will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION.

Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'S name
- Patient's name
- The nature of the appeal
- Any other information that may be helpful for the review.

To request a form to submit a request for review, visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

All correspondence related to a request for a review through BCBSNC's appeals process should be sent to:

BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

In addition, MEMBERS may also receive assistance with ADVERSE BENEFIT DETERMINATIONS from the Managed Care Patient Assistance Program by contacting:
Managed Care Patient Assistance Program
Consumer Protection Division, Office of the Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001
Fax: 1-919-733-6276
Tel: 1-919-733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

You may also receive assistance from the Employee Benefits Security Administration at 1-866-444-3272.

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the appeal, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

Quality Of Care Complaints

For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.

First Level Appeal

BCBSNC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be evaluated by a North Carolina licensed medical doctor who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

Since your health benefit plan is subject to ERISA, the first level appeal is the only level that you must complete before you can pursue your appeal in an action in federal court.

Otherwise, if you are dissatisfied with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your second level appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive from us all information that applies to your appeal
  - attend the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
  - receive instructions on how to request an independent external review through NCDOI upon completion of this review if not satisfied with the decision (available for NONCERTIFICATIONS only).
  - pursue other voluntary alternative dispute resolution options.

The second level appeal meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level appeal. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your appeal even if you do not attend the meeting. A written decision will be issued to you within seven business days of the review meeting.

If you have insurance-related problems or questions at any stage in the review process, you may contact the North Carolina Department of Insurance for assistance. Inquiries may be directed by calling 1-800-546-5664 or by writing to the:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

You may also receive assistance from the Employee Benefits Security Administration at 1-866-444-3272.

Notice of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level appeal or the second level appeal, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and

- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review (Available only for NONCERTIFICATIONS)

North Carolina law provides for review of ADVERSE BENEFIT DETERMINATIONS by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. BCBSNC will notify you of your right to request an external review each time you receive:

- an ADVERSE BENEFIT DETERMINATION, or
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION decision, or
- a second level appeal decision upholding an ADVERSE BENEFIT DETERMINATION.

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

- your request is about a MEDICAL NECESSITY determination that resulted in an ADVERSE BENEFIT DETERMINATION (e.g. NONCERTIFICATION):
- you had coverage with BCBSNC when the ADVERSE BENEFIT DETERMINATION was issued;
- the service for which the ADVERSE BENEFIT DETERMINATION was issued appears to be a covered service; and
- you have exhausted BCBSNC's internal appeals process as described below.

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

- completed BCBSNC's first and second level appeals process and received a written second level determination from BCBSNC, or
- filed a second level appeal and have not requested or agreed to a delay in the second level appeals process, but have not received BCBSNC's written decision within 60 days of the date you can show that the appeal was filed with BCBSNC, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeal and/or second level appeals process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective ADVERSE BENEFIT DETERMINATION (an ADVERSE BENEFIT DETERMINATION which occurs after you have already received the services in question), the 60-day time limit for receiving BCBSNC's second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeals process as referenced above and have received a written second level determination from BCBSNC.

Expedited External Review

An expedited external review may be available if the time required to complete either an expedited internal first or second level appeals review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- an ADVERSE BENEFIT DETERMINATION from BCBSNC and have filed a request with BCBSNC for an expedited first level appeal; or
- a first level appeal decision upholding an ADVERSE BENEFIT DETERMINATION and have filed a request with BCBSNC for an expedited second level appeal; or
- a second level appeal decision (also known as a final internal adverse benefit determination) from BCBSNC.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first level appeal or final internal adverse benefit determination of the admission, availability of care, continued stay or EMERGENCY health care services.

If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if you have exhausted the internal appeals process; or (2) require the completion of the internal appeals process and another request for an external review. An expedited external review is not available for retrospective (post-service) ADVERSE BENEFIT DETERMINATIONS.

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

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

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

(In person)
North Carolina Department of Insurance
Dobbs Building
430 N. Salisbury Street, Suite 4105
Raleigh, NC 27603
Tel: (919) 807-6860
Tel (toll free in NC): (877) 885-0231

(Web): www.ncdoi.com for external review information and request form

The Healthcare Review Program provides consumer counseling on utilization review and appeals issues.

Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your PROVIDER of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BCBSNC upholding an ADVERSE BENEFIT DETERMINATION (generally the notice of a second level appeal decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BCBSNC has provided to the NCDOI; and (iii) a notification that you may submit additional

written information and supporting documentation relevant to the initial ADVERSE BENEFIT DETERMINATION to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION or the second level appeal decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:

Blue Cross Blue Shield of North Carolina
Appeals Department
HQ2540HM
PO Box 30055
Durham, NC 27702-3055

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

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within four business days) of the date the NCDOI received your external review request. If the IRO's decision is to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will, within three business days (or, for an expedited review, within one day) of receiving notice of the IRO's decision, reverse the ADVERSE BENEFIT DETERMINATION and provide coverage for the requested service or supply. If you are no longer covered by BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

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

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Please forward written appeals to:

Magellan Behavioral Health
Appeals Department
PO Box 1619
Alpharetta, GA 30009

Second level appeal is provided by BCBSNC.

Other Revisions To Your Health Benefit Plan

Prescription Drugs

The section of the chart under your Prescription Drug Benefits section concerning SPECIALTY DRUGS is revised to add the description of OUT-OF-NETWORK pharmacy benefits as follows:

	IN-NETWORK	OUT-OF-NETWORK

SPECIALTY DRUGS	BCBSNC has a separate pharmacy network for purchasing select SPECIALTY DRUGS ("Specialty Network"). These select SPECIALTY DRUGS (GENERIC or BRAND NAME) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. If you get your SPECIALTY DRUGS filled by an OUT-OF-NETWORK pharmacy, you may be asked to pay the full cost of the SPECIALTY DRUG and file a claim. You will be reimbursed the ALLOWED AMOUNT less any applicable deductible, coinsurance or copayment. Any charges over the ALLOWED AMOUNT are your responsibility.

Transplants

The following sentence under the first bullet point of this section is deleted: "However, other costs related to evaluation and procurement are covered up to the recipient MEMBER'S coverage limit."

Additional Terms Of Your Coverage

The fifth paragraph under the section "Benefits To Which MEMBERS Are Entitled" is amended to read:

Any amounts paid by BCBSNC for noncovered services or that are in excess of the benefit provided under your Blue Options HSA coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a member's future claims payments. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if BCBSNC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

Glossary

The following term in your booklet is being added as a new definition:

ADVERSE BENEFIT DETERMINATION

A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

The following definitions in your booklet are being revised as follows:

CREDITABLE COVERAGE

Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

GENERIC

A PRESCRIPTION DRUG that has the same active ingredient as a BRAND NAME drug, has the same dosage form and strength as the BRAND NAME drug, and that BCBSNC identifies as a generic. The classification of a PRESCRIPTION DRUG as a generic is determined by BCBSNC based on commercially available data resources.

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under your health benefit plan has been reviewed and does not meet BCBSNC's requirements for MEDICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY

SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

The definition for GRIEVANCE is deleted in its entirety.

WELCOME TO BLUE OPTIONS HSA

Welcome to Blue Cross and Blue Shield of North Carolina's Blue Options HSA plan!

As a MEMBER of the Blue Options HSA plan, you will enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options network.

You may receive, upon request, information about Blue Options HSA, its services and DOCTORS, including this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Please note: The Blue Options HSA plan is intended to be a high-deductible health plan ("HDHP") that qualifies its members to contribute to a health savings account (HSA), unless its members are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the deductible and TOTAL OUT-OF-POCKET MAXIMUM amounts listed in the "Summary Of Benefits" may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

How To Use Your Blue Options HSA Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary Of Benefits" to get an overview of your specific benefits, such as deductible, coinsurance, and maximum amounts
- "COVERED SERVICES" to get more detailed information about what is covered and what is excluded from coverage
- "UTILIZATION MANAGEMENT" for important information about when PRIOR REVIEW and CERTIFICATION are required
- "What Is Not Covered?" to see general exclusions from coverage.

If you still have questions, you can call BCBSNC Customer Service at the number listed on your ID CARD or in "Whom Do I Contact?"

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and will appear in "Glossary" at the end of this benefit booklet. The terms "we," "us," and "BCBSNC" refer to Blue Cross and Blue Shield of North Carolina. Common insurance terms involving your financial responsibility, such as "coinsurance," "coinsurance maximum," and "deductible" are defined in "Understanding Your Share Of The Cost."

You will also want to review the following sections of this benefit booklet:

- "How Blue Options HSA Works" explains the coverage levels available to you
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in this health benefit plan
- "What If You Disagree With Our Decision?" explains the rights available to you when we make a decision and you do not agree.

AVISO PARA LOS AFILIADOS QUE NO HABLAN INGLÉS

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que el plan médico de SU EMPLEADOR le ofrece. Si tiene dificultad en entender alguna sección de este manual, por favor llame al ADMINISTRADOR DE SU GRUPO para recibir ayuda.

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options HSA benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- Coinsurance percentages shown in this section are the part of the ALLOWED AMOUNT that BCBSNC pays
- Deductible and coinsurance amounts are based on the ALLOWED AMOUNT
- Services applied to the deductible also count toward any visit or day maximums
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. **However, in an EMERGENCY, or when IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC's access to care standards, you may also receive IN-NETWORK benefits for care from an OUT-OF-NETWORK PROVIDER. Please see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY Care" for more information. Access to care standards are available on our Web site at bcbsnc.com or by calling BCBSNC Customer Service at the number listed on your ID CARD or in "Whom Do I Contact?"**
- If you see an OUT-OF-NETWORK PROVIDER, you will receive OUT-OF-NETWORK benefits unless otherwise approved by BCBSNC.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed on your ID CARD or in "Whom Do I Contact?"

SPECIAL NOTICE IF YOU CHOOSE AN OUT-OF-NETWORK PROVIDER

Your actual expenses for COVERED SERVICES may exceed the stated coinsurance percentage amount because actual PROVIDER charges may not be used to determine the health benefit plan's and MEMBER'S payment obligations. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, in addition to any deductible and coinsurance amount.

BENEFIT PERIOD - August 1, 2011 through July 31, 2012

Benefits	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM, Deductible, and TOTAL OUT-OF-POCKET MAXIMUM		
LIFETIME MAXIMUM	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY, INFERTILITY and INFERTILITY drugs. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.		
Deductible		
EMPLOYEE, per BENEFIT PERIOD	$5,000	$10,000
Family, per BENEFIT PERIOD	$7,000	$14,000
The deductible corresponds to the type of coverage you have chosen. The EMPLOYEE deductible applies if you selected EMPLOYEE-only coverage; otherwise, the family deductible applies.		
TOTAL OUT-OF-POCKET MAXIMUM		
EMPLOYEE, per BENEFIT PERIOD	$5,000	$11,250
Family, per BENEFIT PERIOD	$7,000	$16,500
The TOTAL OUT-OF-POCKET MAXIMUM, which is the deductible plus the coinsurance you pay, is the total amount you will pay for COVERED SERVICES. The EMPLOYEE TOTAL OUT-OF-POCKET MAXIMUM applies if you selected EMPLOYEE-only coverage; otherwise, the family TOTAL OUT-OF-POCKET MAXIMUM applies.		
PROVIDER'S Office OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined in- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
Office Visit Services		
PRIMARY CARE PROVIDER or SPECIALIST	100% after deductible	70% after deductible
Includes office SURGERY, x-rays, diagnostic imaging and lab tests.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE Services	100%	70% after deductible
Includes routine physical exams and screenings, well-baby and well-child care, and immunizations, routine eye exams, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening. This benefit is only for services that indicate a diagnosis of preventive or wellness. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Therapy Services		
SHORT-TERM REHABILITATIVE THERAPIES	100% after deductible	70% after deductible
Combined in- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings. 30 visits per BENEFIT PERIOD for physical/occupational therapy, including chiropractic services. 30 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
OTHER THERAPIES	100% after deductible	70% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for OTHER THERAPIES provided in an outpatient setting.		
INFERTILITY Services		
PRIMARY CARE PROVIDER or SPECIALIST	100% after deductible	70% after deductible
Combined in- and OUT-OF-NETWORK LIFETIME MAXIMUM of $5,000 per MEMBER for INFERTILITY SERVICES, provided in all places of service (includes INFERTILITY PRESCRIPTION DRUGS). Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.		
Lenses and Frames	$50 per BENEFIT PERIOD	
BCBSNC will reimburse you up to the BENEFIT PERIOD MAXIMUM for prescribed eyeglasses and hard, soft or disposable contact lenses. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
URGENT CARE Centers and Emergency Room		
URGENT CARE Centers	100% after deductible	100% after deductible
PREVENTIVE CARE services received in an URGENT CARE Center	100%	70% after deductible
For a brief list of these services, see "PREVENTIVE CARE Services" under "PROVIDER'S Office" above. This benefit is only for services that indicate a diagnosis of preventive or wellness. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Emergency Room Visit	100% after deductible	100% after deductible
AMBULATORY SURGICAL CENTER		
AMBULATORY SURGICAL Services	100% after deductible	70% after deductible
PREVENTIVE CARE Services	100%	70% after deductible
For a brief list of these services, see "PREVENTIVE CARE Services" under "PROVIDER'S Office" above. This benefit is only for services that indicate a diagnosis of preventive or wellness. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Outpatient		
Outpatient Services	100% after deductible	70% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services, OUTPATIENT CLINIC services, outpatient diagnostic services, and therapy services including SHORT-TERM REHABILITATIVE THERAPIES, and OTHER THERAPIES including dialysis. See PROVIDER'S Office for visit maximums.		
PREVENTIVE CARE Services	100%	70% after deductible
For a brief list of these services, see "PREVENTIVE CARE Services" under "PROVIDER'S Office" above. This benefit is only for services that indicate a diagnosis of preventive or wellness. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		

Benefits	IN-NETWORK	OUT-OF-NETWORK
Inpatient		
Inpatient Services	100% after deductible	70% after deductible
Includes physician services, HOSPITAL and HOSPITAL-based services , and maternity delivery, prenatal and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.		
Skilled Nursing Facility		
	100% after deductible	70% after deductible
Combined in- and OUT-OF-NETWORK maximum of 60 days per BENEFIT PERIOD. Services applied to the deductible count towards this day maximum. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.		
Other Services		
	100% after deductible	70% after deductible
Includes ambulance, DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, and HOME HEALTH care. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to a LIFETIME MAXIMUM of $600. When covered, benefits for hearing aids are limited to $2,500 per hearing-impaired ear every 36 months. Any services in excess of these BENEFIT PERIOD or LIFETIME MAXIMUMS are not COVERED SERVICES.		
Mental Health And Substance Abuse Services		
Mental Health Office Services	100% after deductible	70% after deductible
Mental Health Inpatient/Outpatient Services	100% after deductible	70% after deductible
Substance Abuse Office Services	100% after deductible	70% after deductible
Substance Abuse Inpatient/Outpatient Services	100% after deductible	70% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
CERTIFICATION Requirements		
Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by BCBSNC in order to receive benefits. If you go to an IN-NETWORK PROVIDER in North Carolina, your PROVIDER will request PRIOR REVIEW when necessary. If you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any PROVIDER outside of North Carolina, you are responsible for requesting or ensuring that your PROVIDER requests PRIOR REVIEW by BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. See "COVERED SERVICES" and "Prospective Review/PRIOR REVIEW" in "UTILIZATION MANAGEMENT."**		
BCBSNC delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. PRIOR REVIEW and CERTIFICATION by Magellan Behavioral Health are required for inpatient and certain outpatient mental health and substance abuse services received from an IN-NETWORK PROVIDER, except for EMERGENCIES. Please see the number in "Whom Do I Contact?"		
Prescription Drugs		
PRESCRIPTION DRUGS (GENERIC and BRAND NAME)	100% after deductible	100% after deductible
Designated Preventive PRESCRIPTION DRUGS (GENERIC and BRAND NAME drugs)	100%	100%
Designated Preventive PRESCRIPTION DRUGS (GENERIC drugs only)	100%	100%
Diabetic Supplies	100% after deductible	100% after deductible
Spacers and Peak Flow Meters	100% after deductible	100% after deductible
INFERTILITY drugs are limited to a combined in- and OUT-OF-NETWORK LIFETIME MAXIMUM. See INFERTILITY Services in the "Summary Of Benefits."		
Preventive over-the-counter medications	100%	70% after deductible
Please visit the Web site at **bcbsnc.com/preventive** or call Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify. Also see "PREVENTIVE CARE" in "COVERED SERVICES".		

HOW BLUE OPTIONS HSA WORKS

Blue Options HSA gives you the freedom to choose any PROVIDER - the main difference will be the cost to you. Benefits are available for services from a PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS please visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?". Here is a look at how it works:

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the BlueCard PPO program. IN-NETWORK PROVIDERS agree to limit charges for COVERED SERVICES to the ALLOWED AMOUNT. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on our Web site at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"	OUT-OF-NETWORK PROVIDERS are not designated as a Blue Options PROVIDER by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You pay only the applicable deductible, coinsurance, and non-covered expenses.	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to the applicable deductible, coinsurance, non-covered expenses and CERTIFICATION penalty amounts, if any.
Referrals	You are not required to obtain any referrals.	You are not required to obtain any referrals.
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard Program, and benefits are provided at the IN-NETWORK coinsurance.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. If you receive services outside of North Carolina (even if you see an IN-NETWORK PROVIDER), you are responsible for requesting or ensuring that your PROVIDER requests PRIOR REVIEW by BCBSNC.	You are responsible for requesting or ensuring that your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by BCBSNC. Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after vaginal delivery or 96 hours after Cesarean section.

	For inpatient or outpatient mental health and substance abuse services, either in or outside of North Carolina, contact Magellan Behavioral Health to request PRIOR REVIEW and receive CERTIFICATION. PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay or for an inpatient HOSPITAL stay for 48 hours after vaginal delivery or 96 hours after Cesarean section.	
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC; also see "How To File A Claim."

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at your IN-NETWORK coinsurance. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. If you are billed by the PROVIDER, you will be responsible for paying the bill and filing a claim with BCBSNC.

> For more information, see "EMERGENCY Care," "Continuity Of Care" in "UTILIZATION MANAGEMENT," and for information about BCBSNC's access to care standards, see our Web site at **bcbsnc.com**. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Blue Options HSA MEMBER. **Be sure to carry your ID CARD with you at all times and present it each time you seek health care.**

> For ID CARD requests, please visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Making An Appointment

Call the PROVIDER'S office and identify yourself as a Blue Options HSA MEMBER. If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

If you cannot keep an appointment, call the PROVIDER'S office as soon as possible. Charges for missed appointments, which PROVIDERS may require as part of their routine practice, are not covered.

The Role Of A PRIMARY CARE PROVIDER (PCP) Or SPECIALIST

It is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER

regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

> Please visit our website at **bcbsnc.com** or call BCBSNC Customer Service to be sure the PROVIDER you choose is available to be a PCP. You may want to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "UTILIZATION MANAGEMENT."

Upon the request of the MEMBER and subject to approval by BCBSNC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST, and BCBSNC, with notice to the PCP if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

> To make this request or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

HealthLine Blue

You may call a HealthLine Blue nurse to assist you with medical questions, offer support, and send you free information on health topics appropriate for your condition. MEMBERS may ask to speak with the same nurse on an ongoing basis. You may also visit our Web site at **bcbsnc.com** to search a library of current health topics, send secure messages to the HealthLine Blue nurses, learn about symptoms and medications and use tools that guide you through important health care decisions. See the number listed in "Whom Do I Contact?" to speak to a HealthLine Blue nurse.

How To File A Claim

When you file a claim, mail the completed claim form to:
For mental health and substance abuse services:
BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

For PRESCRIPTION DRUGS:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

For all other medical services:
BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

You may obtain a claim form, including international claim forms, by visiting our Web site at **bcbsnc.com** or calling BCBSNC Customer Service at the number listed in "Whom Do I Contact?" For help filing a claim, call BCBSNC Customer Service or write to:
BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

UNDERSTANDING YOUR SHARE OF THE COST

This section explains how you and BCBSNC share the cost of your health care.

If you receive COVERED SERVICES from an IN-NETWORK PROVIDER you **are not responsible** for any charge over the ALLOWED AMOUNT; however, PROVIDERS may collect an estimated amount of the MEMBER'S deductible and coinsurance when services are provided. If a MEMBER uses Health Savings Account (HSA) funds to pay their PROVIDER and a PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER'S deductible or coinsurance, the MEMBER must return this money to the HSA in order to avoid any tax impacts. If you receive COVERED SERVICES from an OUT-OF-NETWORK PROVIDER, you **are responsible** for the portion of the charge over the ALLOWED AMOUNT.

Deductibles

A deductible is the dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable by BCBSNC. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or expenses for noncovered services. Your deductible amount is determined by your type of coverage. The EMPLOYEE deductible applies if you selected EMPLOYEE-only coverage; otherwise, the family deductible applies. If one or more DEPENDENTS are covered, all covered family members contribute to the same family deductible. Once the family deductible is reached, it is met for all covered family members. However, the family deductible must be met before benefits are payable by BCBSNC for any individual in the family. Please see PREVENTIVE CARE in "COVERED SERVICES" for PREVENTIVE CARE services that are covered even before the deductible is met unless otherwise noted. See "Summary Of Benefits" for your specific deductible amounts.

Note these special rules:

- Amounts applied to your OUT-OF-NETWORK deductible are credited to your IN-NETWORK deductible
- However, amounts applied to your IN-NETWORK deductible are not credited to your OUT-OF-NETWORK deductible.

Coinsurance

Coinsurance is the sharing of charges by BCBSNC and the MEMBER for COVERED SERVICES, after you have satisfied your BENEFIT PERIOD deductible.

Here is an example of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. The scenario is a total outpatient HOSPITAL bill of $5,000.

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	$5,000	$5,000
B. ALLOWED AMOUNT	$4,250	$4,250
C. Deductible Amount	**$2,000**	**$4,000**
D. ALLOWED AMOUNT Minus Deductible (B-C)	$2,250	$250
E. Your Coinsurance Amount (x% times D)	**(10%) $225**	**(30%) $75**
F. Amount You Owe Over ALLOWED AMOUNT	**$0** (IN-NETWORK charges limited to ALLOWED AMOUNT)	**$750** (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	**$2,225**	**$4,825**

Deductible and coinsurance amounts are for example only, please refer to "Summary Of Benefits" for your benefits.

TOTAL OUT-OF-POCKET MAXIMUM

The TOTAL-OUT-OF-POCKET MAXIMUM is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. Your TOTAL OUT-OF-POCKET MAXIMUM is determined by your type of coverage. The EMPLOYEE TOTAL OUT-OF-POCKET MAXIMUM applies if you selected EMPLOYEE only coverage; otherwise, the family TOTAL OUT-OF-POCKET MAXIMUM applies. If one or more DEPENDENTS are covered under Blue Options HSA, all covered family members contribute to the same family TOTAL OUT-OF-POCKET MAXIMUM. When **either** the family IN-NETWORK or OUT-OF-NETWORK TOTAL OUT-OF-POCKET MAXIMUM is met, the family TOTAL OUT-OF-POCKET MAXIMUM is met for all covered family members.

Note these special rules:

- Charges over ALLOWED AMOUNTS and charges for noncovered services are not included in the TOTAL OUT-OF-POCKET MAXIMUM
- Charges for IN-NETWORK services apply to the IN-NETWORK TOTAL OUT-OF-POCKET MAXIMUM
- Charges for OUT-OF-NETWORK services apply to both the OUT-OF-NETWORK and the IN-NETWORK TOTAL OUT-OF-POCKET MAXIMUMS.

Blue Options HSA covers only those services that are MEDICALLY NECESSARY. Also keep in mind as you read this section:

- **Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a partial (penalty) or full denial of benefits. General categories of services are noted below as requiring PRIOR REVIEW. Also see "Prospective Review/PRIOR REVIEW" in "UTILIZATION MANAGEMENT" for information about the review process, visit our Web site at bcbsnc.com, or call BCBSNC Customer Service to ask whether a specific service requires PRIOR REVIEW and CERTIFICATION.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary Of Benefits" and "What Is Not Covered?"
- You may also receive, upon request, information about the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about our medical policies, see our Web site at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Office Services

Care you receive as part of an OFFICE VISIT or house call is covered. Your health benefit plan also provides benefits for a total of six nutritional counseling visits per BENEFIT PERIOD to an in- or OUT-OF-NETWORK PROVIDER for those MEMBERS who participate in BCBSNC's Member Health Partnerships[sm] program. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight.

Certain diagnostic imaging procedures, such as CT scans, PET scans, and MRIs, may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Office Services Exclusion

- Certain self-injectable PRESCRIPTION DRUGS that can be self-administered. The list of these drugs may change from time to time. See our Web site at **bcbsnc.com** or call BCBSNC Customer Service for a list of these drugs excluded in the office. Also see "PRESCRIPTION DRUG Benefits" for information about purchasing self-injectable PRESCRIPTION DRUGS at a pharmacy.

PREVENTIVE CARE

Your health benefit plan covers PREVENTIVE CARE services that can help you stay safe and healthy.

PREVENTIVE CARE services include:

Routine Physical Examinations

One routine physical examination and related diagnostic services per BENEFIT PERIOD will be covered for each MEMBER age three and older.

Well-Baby And Well-Child Care

These services are covered for each MEMBER including periodic assessments and immunizations as recommended by the American Academy of Pediatrics and the United States Preventive Services Task Force.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Immunizations Exclusions

- Immunizations required for occupational hazard
- Immunizations required for international travel.

Please log on to our Web site at **bcbsnc.com** and click the Health Resources tab and then Guidelines for Staying Healthy for the most up-to-date information or call BCBSNC at 1-800-218-5295.

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female MEMBERS ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female MEMBER is considered "at risk" if she:

- Has 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
- Tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Your health benefit plan provides coverage for one baseline mammogram for any female MEMBER between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female MEMBER per calendar year, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic MEMBER who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high-risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings.

The PROVIDER search on our Web site at **bcbsnc.com** can help you find office-based PROVIDERS, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per BENEFIT PERIOD. More PSA tests will be covered if recommended by a DOCTOR.

Bone Mass Measurement Services

Your health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Qualified individuals include MEMBERS who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy

- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your DOCTOR find the cause and extent of your condition in order to plan for your care.

Certain diagnostic imaging procedures, such as CT scans, PET scans, and MRIs, may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Your DOCTOR may refer you to a freestanding radiology center for these procedures. Separate benefits for interpretation of diagnostic services by the attending DOCTOR are not provided in addition to benefits for that DOCTOR'S medical or surgical services, except as otherwise determined by BCBSNC.

EMERGENCY Care

Your health benefit plan provides benefits for EMERGENCY SERVICES. An EMERGENCY is the sudden and unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

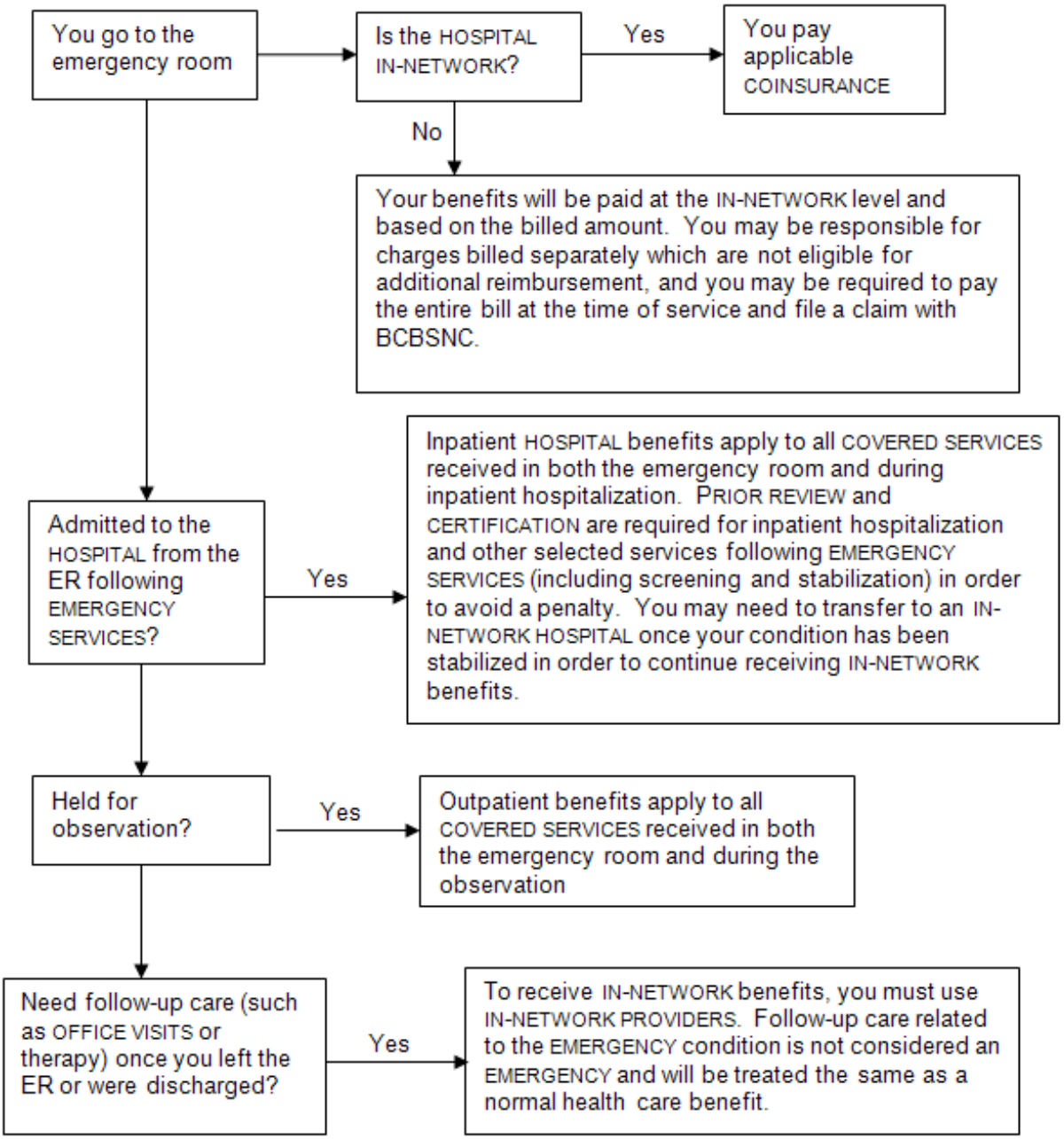
Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of EMERGENCIES.

What To Do In An EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue, and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

PRIOR REVIEW is not required for EMERGENCY SERVICES.

What are my benefits when I receive services in the emergency room?



URGENT CARE

Your health benefit plan also provides benefits for URGENT CARE services. When you need URGENT CARE, call your PCP, a SPECIALIST or go to an URGENT CARE PROVIDER. If you are not sure if your condition requires URGENT CARE, you can call HealthLine Blue.

URGENT CARE includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the MEMBER could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, dizziness, and some lacerations are examples of conditions that would be considered urgent.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. Maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		Deductible and coinsurance apply
Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section. Mothers choosing a shorter stay are eligible for a HOME HEALTH visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well baby care for 48 hours after a vaginal delivery or 96 hours after a Cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (please see PREVENTIVE CARE in "Summary Of Benefits")	Deductible and coinsurance apply
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours.	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required in order to avoid a penalty.	If adding the baby changes your policy from individual to family coverage, the family BENEFIT PERIOD deductible applies.

For information on CERTIFICATION, contact BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Statement Of Rights Under The Newborns' And Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending PROVIDER (e.g., your DOCTOR, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a DOCTOR or other health care PROVIDER obtain CERTIFICATION for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, or to reduce your out-of-pocket costs, you may be required to obtain CERTIFICATION.

COMPLICATIONS OF PREGNANCY

Benefits for COMPLICATIONS OF PREGNANCY are available to all female MEMBERS including DEPENDENT CHILDREN. Please see "Glossary" for an explanation of COMPLICATIONS OF PREGNANCY.

INFERTILITY Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN. Refer to "Summary Of Benefits" for limitations that may apply. For information about coverage of INFERTILITY PRESCRIPTION DRUGS, see "PRESCRIPTION DRUG Benefits."

SEXUAL DYSFUNCTION Services

Your health benefit plan provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS.

Sterilization

This benefit is available for all MEMBERS. Sterilization includes female tubal ligation and male vasectomy.

Contraceptive Devices

This benefit is available for all MEMBERS. Coverage includes the insertion or removal of and any MEDICALLY NECESSARY examination associated with the use of intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives. See "PRESCRIPTION DRUG Benefits" for coverage of oral contraceptives.

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian transfer (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN
  - elective termination of pregnancy
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

FACILITY SERVICES

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or an OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the Blue Options network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. Take home drugs are covered as part of your PRESCRIPTION DRUG benefit. PRIOR REVIEW must be requested and

CERTIFICATION must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY Care."
- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC to avoid a penalty. SKILLED NURSING FACILITY services are limited to a combined IN-NETWORK and OUT OF NETWORK day maximum per BENEFIT PERIOD.

Other Services

Ambulance Services

Your health benefit plan covers services in a ground ambulance traveling:
- From a MEMBER'S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY

when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER'S home when MEDICALLY NECESSARY.

Your health benefit plan covers services in an air ambulance traveling from the site of an EMERGENCY to a HOSPITAL when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Blood

Your benefits cover the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a MEMBER'S own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the MEMBER in the case of autologous blood donation.

Clinical Trials

Your health benefit plan provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-INVESTIGATIONAL alternatives. In addition, the trial must:
- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical SPECIALISTS
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase I
- Non-health care services, such as services provided for data collection and analysis
- INVESTIGATIONAL drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

Your health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- CONGENITAL deformity, including cleft lip and cleft palate
- Removal of:
  - tumors
  - cysts which are not related to teeth or associated dental procedures
  - exostoses for reasons other than for preparation for dentures.

Your health benefit plan provides benefits for dental implants and related procedures, such as bone grafting, associated with the above three conditions. Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, benefits for SURGERY will be subject to MEDICAL NECESSITY review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth. In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a HOSPITAL or AMBULATORY SURGICAL CENTER. This benefit is only available to DEPENDENT CHILDREN below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other DENTAL SERVICES, including the charge for SURGERY, are not covered unless specifically covered by your health benefit plan.

In addition, benefits will be provided if a MEMBER is treated in a HOSPITAL following an accidental injury, and COVERED SERVICES such as oral SURGERY or reconstructive procedures are required at the same time as treatment for the bodily injury.

Unless reconstructive DENTAL SERVICES following accidental injury are related to the bones or joints of the jaw, face, or head, reconstructive DENTAL SERVICES are covered only when provided within two years of the accident.

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or services will not be covered, unless treatment is for an EMERGENCY.

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor

And except as specifically stated as covered, treatment such as:

- Dental implants or root canals
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures
- Crowns, bridges, dentures or in-mouth appliances.

Diabetes-Related Services

All MEDICALLY NECESSARY diabetes-related services, including equipment, supplies, medications and laboratory procedures are covered. Diabetic outpatient self-management training and educational services are also covered.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a DOCTOR. Equipment may be purchased or rented at the discretion of BCBSNC. BCBSNC provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer MEDICALLY NECESSARY. Certain DURABLE MEDICAL EQUIPMENT requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

DURABLE MEDICAL EQUIPMENT Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment.

HOME HEALTH Care

HOME HEALTH care services are covered when you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care services like SHORT-TERM REHABILITATIVE THERAPIES. Services from a HOME HEALTH aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home. These services are covered by BCBSNC when MEDICALLY NECESSARY and when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury. Usually a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. HOME HEALTH care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOME HEALTH Care Exclusions

- Dietitian services or meals
- Homemaker services, such as cooking and housekeeping
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of PRESCRIPTION DRUGS directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of an RN or LPN. PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

HOSPICE Services

Your coverage provides benefits for HOSPICE services for care of a terminally ill MEMBER with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a DOCTOR that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

HOSPICE Services Exclusion

- Homemaker services, such as cooking, housekeeping, and food or meal preparation.

Lymphedema-Related Services

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. Benefits include MEDICALLY NECESSARY equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only when prescribed by a DOCTOR and custom-fit for the patient.

Lymphedema-Related Services Exclusion

- Over-the-counter compression or elastic knee-high or other stocking products.

MEDICAL SUPPLIES

Coverage is provided for MEDICAL SUPPLIES. Select diabetic supplies and spacers for metered dose inhalers and peak flow meters are also covered under your PRESCRIPTION DRUG benefit.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on our Web site at **bcbsnc.com** or call BCBSNC Customer Service.

MEDICAL SUPPLIES Exclusion

- MEDICAL SUPPLIES not ordered by a DOCTOR for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if MEDICALLY NECESSARY and prescribed by a PROVIDER. Foot orthotics may be covered only when custom molded to the patient. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

Your health benefit plan provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through HOME HEALTH AGENCY. See "Care Management". PRIOR REVIEW must be requested and CERTIFICATION must be obtained or services will not be covered.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

PROSTHETIC APPLIANCES

Your coverage provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCES must replace all or part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract SURGERY. For subsequent lens replacements, see "Lenses and Frames." Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered.

PROSTHETIC APPLIANCES Exclusions

- Dental appliances except when MEDICALLY NECESSARY for the treatment of temporomandibular joint disease
- COSMETIC improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under this health benefit plan.

Surgical Benefits

Surgical benefits by a professional or facility PROVIDER on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic SURGERY, such as biopsies, sigmoidoscopies and colonoscopies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive and FOSTER CHILDREN.

Certain surgical procedures, including those that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to BCBSNC's medical policies, which are on our Web site at **bcbsnc.com,** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block, or monitored regional anesthesia ordered by the attending DOCTOR and administered by or under the supervision of a DOCTOR other than the attending surgeon or assistant at SURGERY. Benefits are not available for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, your health benefit plan provides for the following services related to mastectomy SURGERY:

- Reconstruction of the breast on which the mastectomy has been performed
- SURGERY and reconstruction of the nondiseased breast to produce a symmetrical appearance, without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Please note that the decision to discharge the patient following mastectomy SURGERY is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same deductibles, coinsurance and limitations as applied to other medical and surgical benefits provided under this health benefit plan.

Temporomandibular Joint (TMJ) Services

Your health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones. Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving surgical treatment for TMJ.

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or these services will not be covered, unless treatment is for an EMERGENCY.

Temporomandibular Joint (TMJ) Services Exclusions

- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions.

Therapies

Your health benefit plan provides coverage for the following therapy services to promote the recovery of a MEMBER from an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

SHORT-TERM REHABILITATIVE THERAPIES

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a MEMBER'S condition:

- Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation)
- Speech therapy.

Benefits are limited to a combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD visit maximum for each of these two categories of therapies: (1) occupational and/or physical therapy, or any combination of these

therapies; and (2) speech therapy. These visit limits apply in all places of service except inpatient (e.g., outpatient, office and home) regardless of the type of PROVIDER (chiropractors, other DOCTORS, physical therapists). SHORT-TERM REHABILITATIVE THERAPY received while an inpatient is not included in the BENEFIT PERIOD MAXIMUM. See "Summary Of Benefits" for additional information.

OTHER THERAPIES

Your health benefit plan covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is INVESTIGATIONAL but will be covered upon PRIOR REVIEW and CERTIFICATION, based on meeting the American Society of Breast Surgeons (ASBS) criteria.
- Chemotherapy, including intravenous chemotherapy. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants." Also see "PRESCRIPTION DRUG Benefits" regarding related covered PRESCRIPTION DRUGS.

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering
- Group classes for pulmonary rehabilitation.

Transplants

Your health benefit plan provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. BCBSNC provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed based on BCBSNC guidelines that are available upon request from a transplant coordinator.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" to speak with a transplant coordinator and request PRIOR REVIEW. CERTIFICATION must be obtained in advance from BCBSNC for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive SURGERY are not considered transplants.

If a transplant is provided from a living donor to the recipient MEMBER who will receive the transplant:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per transplant. However, other costs related to evaluation and procurement are covered up to the recipient MEMBER'S coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a MEMBER. Benefits provided to the donor will be charged against the recipient's coverage.

Some transplant services are INVESTIGATIONAL and not covered for some or all conditions or illnesses. Please see "Glossary" for an explanation of INVESTIGATIONAL.

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient MEMBER
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a MEMBER
- Transplants, including high dose chemotherapy, considered EXPERIMENTAL or INVESTIGATIONAL
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health And Substance Abuse Services

Your health benefit plan provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or other PROVIDER.

Your coverage for IN-NETWORK inpatient and outpatient services is coordinated through Magellan Behavioral Health. BCBSNC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. See "How To Access Mental Health And Substance Abuse Services."

OFFICE VISIT Services

PRIOR REVIEW by Magellan Behavioral Health is not required for OFFICE VISIT services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- MEDICALLY NECESSARY biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules only apply to MENTAL ILLNESS OFFICE VISITS:

- Each service provided by a mental health PROVIDER will count as one visit
- Any mental health therapy services provided by a non-mental health PROVIDER during the course of an OFFICE VISIT will count as one visit.

Outpatient Services

Covered outpatient services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under OFFICE VISIT services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered inpatient treatment services also include:

- Each service listed in this section under OFFICE VISIT services
- Semi-private room and board
- Detoxification to treat substance abuse.

How To Access Mental Health And Substance Abuse Services

PRIOR REVIEW by Magellan Behavioral Health is not required for OFFICE VISIT services, or for services from an OUT-OF-NETWORK PROVIDER which will be paid at the OUT-OF-NETWORK benefit level. Although PRIOR REVIEW is not required for EMERGENCY situations, please notify Magellan Behavioral Health of your inpatient admission as soon as reasonably possible. If you choose to receive nonemergency inpatient or outpatient services from an IN-NETWORK PROVIDER without requesting PRIOR REVIEW and receiving CERTIFICATION from Magellan Behavioral Health, you will receive coverage at the OUT-OF-NETWORK benefit level. You will also be responsible for the difference between the ALLOWED AMOUNT and the PROVIDER'S full charge. These services are still subject to MEDICAL NECESSITY.

When you need inpatient or outpatient treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Contact?" The Magellan Behavioral Health customer service representative will refer you to an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Counseling with relatives about a patient
- Inpatient confinements that are primarily intended as a change of environment.

PRESCRIPTION DRUG Benefits

Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including insulin or other self-administered injectable medications, and contraceptive drugs and devices
- Certain over-the-counter drugs when listed as covered in the FORMULARY, and a PROVIDER'S PRESCRIPTION for that drug is presented at the pharmacy
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to treatment of INFERTILITY and SEXUAL DYSFUNCTION

- PRESCRIPTION DRUGS approved by the Food and Drug Administration (FDA) for long-term use in the treatment of clinical obesity
- Diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices. Benefits vary for MEDICAL SUPPLIES, depending on whether supplies are received at a MEDICAL SUPPLY PROVIDER or at a pharmacy. See "Summary Of Benefits."

The following information will help you get the most value from your PRESCRIPTION DRUG coverage:

	IN-NETWORK	OUT-OF-NETWORK
Where you get your PRESCRIPTION filled	Your cost will be less if you use an IN-NETWORK pharmacy in North Carolina or outside the state and show your ID CARD. The list of IN-NETWORK pharmacies may change from time to time.	You may also get your PRESCRIPTION filled by an OUT-OF-NETWORK pharmacy; however, you may be asked to pay the full cost of the PRESCRIPTION DRUG and file a claim. You will be reimbursed the ALLOWED AMOUNT less any applicable deductible, coinsurance or copayment. Any charges over the ALLOWED AMOUNT are your responsibility. If you had an EMERGENCY or URGENT CARE condition and went to an OUT-OF-NETWORK pharmacy, we recommend that you call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" so that the claim can be processed at the IN-NETWORK level.
How your PRESCRIPTION is dispensed	You may buy up to a 90-day supply of PRESCRIPTION DRUGS if allowed by your PRESCRIPTION. To receive an extended supply of PRESCRIPTION DRUGS through the mail, please have your PROVIDER write a new PRESCRIPTION for up to 90 days, and request a mail order form by selecting the "Find a drug" tab and then the "Mail order drug program" link at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. If these drugs are subject to a copayment, you will pay either two to three copayments depending on the quantity you receive. Please note that you cannot refill a PRESCRIPTION until: • three-fourths of the time period has passed that the PRESCRIPTION was intended to cover, or • the full time period has passed that the PRESCRIPTION was intended to cover for those PRESCRIPTION DRUGS with quantity limits, except during a government-declared state of emergency or disaster in the county in which you reside. The ability to request a refill under these circumstances is limited to a request made within 29 days after the origination date of the conditions causing the declared state of emergency or disaster. A refill of a PRESCRIPTION with quantity limitations may take into account the proportionate dosage use prior to the disaster.	
Use of GENERIC PRESCRIPTION DRUGS	When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG, such as a GENERIC, could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND NAME PRESCRIPTION DRUG, your cost will be higher.	

	From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs.
PRIOR REVIEW Requirements	PRIOR REVIEW and CERTIFICATION by BCBSNC are required for some PRESCRIPTION DRUGS. BCBSNC may change the list of these PRESCRIPTION DRUGS from time to time.
SPECIALTY DRUGS	BCBSNC has a separate pharmacy network for purchasing select SPECIALTY DRUGS ("Specialty Network"). These select SPECIALTY DRUGS (GENERIC or BRAND NAME) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits.
Restricted Access Drugs and Devices	For certain PRESCRIPTION DRUGS to be covered, BCBSNC requires that the MEMBER has tried a preferred drug or device. Coverage for these PRESCRIPTION DRUGS may be provided without the use of a preferred drug or device if the PROVIDER certifies in writing that the MEMBER has previously used a preferred drug or device and the preferred drug or device has been detrimental to the MEMBER'S health or has been ineffective in treating the same condition and, in the opinion of the PROVIDER, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition in the future.
Quantity Limitations	BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by BCBSNC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.
Benefit Limitations	BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity as a benefit limitation. Excess quantities are not covered. Such limitations may include: _ the amount dispensed per PRESCRIPTION, including the amount dispensed per day or for a defined time period _ the amount dispensed per lifetime _ the amount dispensed per month's supply
Where to find more information	You may visit our Web site at **bcbsnc.com** or call Customer Service at the number listed in "Whom Do I Contact?" for the following: • List of IN-NETWORK pharmacies (including the Specialty Network) • List of PRESCRIPTION DRUGS that: _ require PRIOR REVIEW and CERTIFICATION _ are restricted access drugs and devices _ are subject to benefit limitations _ are subject to quantity limitations _ must be dispensed through the Specialty Network in order to receive IN-NETWORK benefits • Any special programs that may apply • A copy of the FORMULARY

Your EMPLOYER has chosen an enhanced preventive PRESCRIPTION DRUG benefit. Certain PRESCRIPTION DRUGS will not be subject to deductible or coinsurance if prescribed for preventive reasons, such as lowering cholesterol or high blood pressure. Please see PRESCRIPTION DRUGS in the “Summary Of Benefits.” You may visit our Web

site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for a list of preventive PRESCRIPTION DRUGS. This list may change from time to time.

PRESCRIPTION DRUG Benefits Exclusions

Any PRESCRIPTION DRUG that is:

- Not specifically covered in your health benefit plan
- In excess of the stated quantity limits unless otherwise noted
- Purchased to replace a lost, broken, or destroyed PRESCRIPTION DRUG except under certain circumstances during a state of emergency or disaster
- Any portion or refill which exceeds the maximum supply for which benefits will be provided when dispensed under any one PRESCRIPTION

And any other drug that is:

- Purchased over-the-counter without a PRESCRIPTION, even though a written PRESCRIPTION is provided, unless specifically listed as covered in the FORMULARY
- Therapeutically equivalent to an over-the-counter drug
- Compounded and does not contain at least one ingredient that requires a PRESCRIPTION.
- Contraindicated (should not be used) due to age, gender, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA's approved product labeling.

Lenses And Frames

Your health benefit plan provides reimbursement for COVERED SERVICES for routine vision correction including eyeglass frames and prescribed lenses for single vision, bifocal or trifocal and hard, soft or disposable contact lenses. This does not include any service covered as a PROSTHETIC APPLIANCE. Benefits are limited to a dollar amount per BENEFIT PERIOD. See "Summary Of Benefits."

You may obtain services from any PROVIDER to receive this benefit. You will be required to pay for the services and then file a claim with BCBSNC for reimbursement.

Exclusions for a specific type of service are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all the exclusions that apply, read "COVERED SERVICES", "Summary Of Benefits" and "What Is Not Covered?" Your health benefit plan does not cover services, supplies, drugs or charges 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
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the EMPLOYEE, EMPLOYER or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- 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
- Services received in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

In addition, your health benefit plan does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

Administrative charges billed by a PROVIDER, including charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, obtaining medical records, and late payments

Costs in excess of the **ALLOWED AMOUNT** for services usually provided by one DOCTOR, when those services are provided by multiple DOCTORS or medical care provided by more than one DOCTOR for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER

Side effects and **complications** of noncovered services, except for EMERGENCY SERVICES in the case of an EMERGENCY

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

COSMETIC services, which include removal of excess skin from the abdomen, arms or thighs, and SURGERY for psychological or emotional reasons, except as specifically covered by your health benefit plan

Services received either before or after the **coverage period** of your health benefit plan, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care, which is care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is

there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the PROVIDER prescribing or providing the services.

D

DENTAL SERVICES provided in a HOSPITAL, except as specifically covered by your health benefit plan

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your health benefit plan

The following **drugs**:

- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required
- EXPERIMENTAL drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The ThomsonMicromedex DrugDex
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by your health benefit plan

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or memberships to health clubs
- Personal computers.

EXPERIMENTAL services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by your health benefit plan

F

ROUTINE **FOOT CARE** that is palliative or COSMETIC

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Routine **hearing** examinations and **hearing aids** or examinations for the fitting of hearing aids except as specifically covered by your health benefit plan

Holistic medicine services, which are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any OTHER PROVIDER

Hypnosis except when used for control of acute or chronic pain

I

Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.

Services that are **INVESTIGATIONAL** in nature or obsolete, including any service, drugs, procedure or treatment directly related to an INVESTIGATIONAL treatment, except as specifically covered by your health benefit plan

L

Services provided and billed by a **lactation consultant**

M

Services or supplies deemed not **MEDICALLY NECESSARY**

N

Services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY. This includes any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, services deemed not MEDICALLY NECESSARY, or elective termination of pregnancy if not specifically covered by your health benefit plan.

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a MEMBER or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan

P

Care or services from a **PROVIDER** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER'S license or certification
- Provides and bills for services from a licensed health care professional who is in training
- Is in a MEMBER'S immediate family
- Is not recognized by BCBSNC as an eligible PROVIDER

Ear **piercing**

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a HOSPITAL
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution

Respite care, whether in the home or in a facility or inpatient setting, except as specifically covered by your health benefit plan

S

Services or **supplies** that are:

- Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER
- Available to a MEMBER without charge

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

SEXUAL DYSFUNCTION unrelated to organic disease

Shoe lifts, and shoes of any type unless part of a brace

Services, supplies, drugs or equipment used for the control or treatment of **stammering** or **stuttering**

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- MAINTENANCE THERAPY
- Massage therapy

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except as specifically covered by your health benefit plan

V

The following **vision** services:

- Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Orthoptics, vision training, and low vision aids

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for PRESCRIPTION prenatal vitamins or PRESCRIPTION vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency

W

Wigs, hair pieces and hair implants for any reason

EMPLOYEES shall be added to coverage no later than 90 days after their first day of employment. The term "EMPLOYEE" means a nonseasonal person who works full-time, 30 or more hours per week and is otherwise eligible for coverage. Your EMPLOYER may allow eligibility to extend to other persons, such as retirees or part-time EMPLOYEES.

For DEPENDENTS to be covered under this health benefit plan, you must be covered and your DEPENDENT must be one of the following:

- Your spouse, under a legally valid, existing marriage between persons of the opposite sex
- Your or your spouse's DEPENDENT CHILDREN to their 26th birthday. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in the "Glossary."
- A DEPENDENT CHILD who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the health benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the age of 26. The handicap must be medically certified by the child's DOCTOR and may be verified annually by BCBSNC.

Enrolling In This Health Benefit Plan

It is very important whether you apply for coverage and/or add DEPENDENTS at your first opportunity or delay your application. When you apply for coverage will determine whether you and your DEPENDENTS are timely or late enrollees and the length of any waiting period for PRE-EXISTING CONDITIONS.

Waiting Periods For PRE-EXISTING CONDITIONS

You and your DEPENDENTS age 19 and older may have to satisfy a waiting period for PRE-EXISTING CONDITIONS under this health benefit plan. Any waiting period for PRE-EXISTING CONDITIONS begins on the enrollment date. For purposes of a PRE-EXISTING CONDITION waiting period, the enrollment date is the first day of coverage under this health benefit plan or the first day of any probationary period, whichever is earlier.

During a waiting period for PRE-EXISTING CONDITIONS neither you nor your DEPENDENTS age 19 and older will receive benefits for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the enrollment date. However, provided there was no significant break in coverage, a waiting period for PRE-EXISTING CONDITIONS will not apply to any condition first identified, treated and covered under prior CREDITABLE COVERAGE. Medical records may be ordered to make these determinations. Pregnancy and genetic information are never treated as PRE-EXISTING CONDITIONS.

For purposes of determining the specifics around any waiting period for PRE-EXISTING CONDITIONS, a "significant break in coverage" is 63 or more consecutive days prior to the enrollment date, during which you have no proof of CREDITABLE COVERAGE.

The waiting period for PRE-EXISTING CONDITIONS will be reduced by the number of days you or your DEPENDENTS had prior CREDITABLE COVERAGE, so long as there was no significant break in coverage. The Certificate of Creditable Coverage or other evidence of CREDIBLE COVERAGE can be provided as soon as reasonably possible.

Timely Enrollees

Timely enrollees are subject to a 12-month waiting period for PRE-EXISTING CONDITIONS. Newborns, adoptive children, FOSTER CHILDREN, children under age 19 and eligible children who are added as a result of a court order such as a Qualified Medical Child Support Order (QMCSO) are not subject to a WAITING PERIOD.

You are a timely enrollee if you apply for coverage and/or add DEPENDENTS within a 30-day period following any of the qualifying events listed below unless otherwise noted. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered qualifying events:

- You or your DEPENDENTS become eligible for coverage under this health benefit plan
- You get married or obtain a DEPENDENT through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:

- you and/or your DEPENDENTS are otherwise eligible for coverage under this health benefit plan, and
- you and/or your DEPENDENTS were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
- you and/or your DEPENDENTS lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of DEPENDENT status, death of the employee, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.

- You or your DEPENDENTS lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days.
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this health benefit plan under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days.

Late Enrollees

If you are applying for coverage at a time which does not qualify you or your DEPENDENTS as timely enrollees as stated above, then you are considered late enrollees. Late enrollees are subject to a(n) 12-month waiting period for PRE-EXISTING CONDITIONS.

Adding Or Removing A Dependent

Do you want to add or remove a DEPENDENT? You must notify your GROUP ADMINISTRATOR and fill out any required forms.

For coverage to be effective on the date the DEPENDENT becomes eligible, your form must be completed within 30 days after the DEPENDENT becomes eligible. However, if you are adding a newborn child, a child legally placed for adoption or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, the date of placement for adoption for adoptive children, or the date of placement of a FOSTER CHILD in your home), as long as coverage was effective on that date. In these cases, notice is not required by BCBSNC within 30 days after the child becomes eligible, but it is important to provide notification as soon as possible.

DEPENDENTS must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, marriage, or when a spouse is no longer eligible due to divorce or death. Failure to timely notify your GROUP ADMINISTRATOR of the need to remove a DEPENDENT could result in loss of eligibility for continuation of coverage.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order that is issued by an appropriate court or through an administrative process under state law that: (1) provides for coverage of the child of a MEMBER under BCBSNC; and (2) is either issued according to state law or a law relating to medical child support described in Section 1908 of the Social Security Act. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. A copy of the QMCSO procedures may be obtained free of charge from your GROUP ADMINISTRATOR.

Types Of Coverage

These are the types of coverage available:

- Employee-only coverage - The health benefit plan covers only you
- Employee-spouse coverage - The health benefit plan covers you and your spouse
- Employee-children coverage - The health benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage - The health benefit plan covers you, your spouse and your DEPENDENT CHILDREN.

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your GROUP ADMINISTRATOR and fill out the proper form. It will help us give you better service if BCBSNC is kept informed of these changes.

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this health benefit plan may end. You may have certain options such as enrolling in Medicare, continuing health insurance under this health benefit plan, or purchasing an individual conversion policy.

Medicare

When you reach age 65, you may be eligible for Medicare Part A hospital, Medicare Part B medical, and Medicare Part D prescription drug benefits. You may be eligible for Medicare benefits earlier if you become permanently disabled or develop end-stage renal disease. Just before either you or your spouse turn 65, or when disability or end-stage renal disease occurs, you should contact the nearest Social Security office and apply for Medicare benefits. They can tell you what Medicare benefits are available.

If you are covered by this health benefit plan when you become eligible for Medicare, consult your GROUP ADMINISTRATOR, who will advise you about continuation of coverage under this health benefit plan.

Continuation Under Federal Law

Under a federal law known as COBRA, if your EMPLOYER has 20 or more employees, you and your covered DEPENDENTS can elect to continue coverage for up to 18 months by paying applicable fees to the EMPLOYER in the following circumstances:

- Your employment is terminated (unless the termination is the result of gross misconduct)
- Your hours worked are reduced, causing you to be ineligible for coverage.

In addition to their rights above, DEPENDENTS will be able to continue coverage for up to 36 months if their coverage is terminated due to:

- Your death
- Divorce
- Your entitlement to Medicare
- A DEPENDENT CHILD ceasing to be a DEPENDENT under the terms of this coverage.

Children born to or placed for adoption with you during the continuation coverage period are also eligible for the remainder of the continuation period.

If you are a retired EMPLOYEE and your EMPLOYER allows coverage to extend to retirees under this health benefit plan, and you, your spouse and your DEPENDENTS lose coverage resulting from a bankruptcy proceeding against your EMPLOYER, you may qualify for continuation coverage under COBRA. Contact your GROUP ADMINISTRATOR for conditions and duration of continuation coverage.

In addition, you and/or your DEPENDENTS, who are determined by the Social Security Administration to be disabled, may be eligible to extend their 18-month period of continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be provided to the GROUP ADMINISTRATOR within 60 days of the determination of disability by the Social Security Administration and prior to the end of the original 18-month period of continuation coverage. In addition, notice must be provided to the GROUP ADMINISTRATOR within 30 days after the later of the date of determination that the individual is no longer disabled or the date of the initial notification of this notice requirement.

You or your DEPENDENTS must notify the GROUP ADMINISTRATOR within 60 days of the following qualifying events:

- Divorce
- Ineligibility of a DEPENDENT CHILD.

You and/or your DEPENDENTS will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the termination of your coverage.

Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days.

Continuation coverage will end at the completion of the applicable continuation period or earlier if:

- Your EMPLOYER ceases to provide a health benefit plan to EMPLOYEES
- The continuing person fails to pay the monthly fee on time
- The continuing person obtains coverage under another group plan, unless the new group plan excludes or limits coverage for PRE-EXISTING CONDITIONS and the continuing person does not have enough prior CREDITABLE COVERAGE to satisfy any new waiting period for PRE-EXISTING CONDITIONS that would apply. (In this case, continuation coverage will be the secondary payer, with the exception of claims for PRE-EXISTING CONDITIONS. Continuation coverage will be the primary payer of claims for PRE-EXISTING CONDITIONS.)
- The continuing person becomes entitled to Medicare after the election of continuation coverage.

If you are covered by this health benefit plan and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult your GROUP ADMINISTRATOR. Your GROUP ADMINISTRATOR will advise you about the continuation of coverage and reinstatement of coverage under this health benefit plan as required under USERRA.

If you have any questions about your COBRA rights or continuation of coverage, please contact your GROUP ADMINISTRATOR.

Continuation Under State Law

Under state law, you and your covered DEPENDENTS of any employer-size group have the option to continue group coverage for 18 months from the date that you and/or your DEPENDENTS cease to be eligible for coverage under this health benefit plan. You and your DEPENDENTS are not eligible for continuation under state law if:

- Your insurance terminated because you failed to pay the appropriate contribution
- You or your DEPENDENTS are eligible for another group health benefit plan
- You were covered less than three consecutive months prior to termination.

You and/or your DEPENDENTS must notify the GROUP ADMINISTRATOR if you or your DEPENDENTS intend to continue coverage and pay the applicable fees within 60 days following the end of eligibility. Upon receipt of the notice of continuation and applicable fees, BCBSNC will reinstate coverage back to the date eligibility ended. The state law continuation benefits run concurrently and not in addition to any applicable federal continuation rights.

Under state law, continuation of coverage under this health benefit plan will end at the completion of the applicable continuation period or earlier if:

- Your EMPLOYER ceases to provide a health benefit plan to EMPLOYEES
- The continuing person fails to pay the monthly fee
- The continuing person obtains similar coverage under another group plan.

When My Coverage Under This Health Benefit Plan Ends

Persons who have elected to continue with individual coverage will be contacted by the GROUP ADMINISTRATOR within 180 days before the end of their continuation period and offered individual conversion coverage.

If you or your DEPENDENTS are no longer eligible for coverage under this health benefit plan, you may transfer to individual conversion coverage without a medical examination or review of medical records. For continuous coverage, ensure that your premiums are paid during the continuation period. BCBSNC must be notified within 31 days of loss of eligibility. You must fill out a Conversion Coverage Enrollment and Change Application and pay the applicable premium. Services during the 31-day conversion period will be covered only if the premium is received before the end of the 31-day period.

Persons who have exhausted their continuation coverage rights may also be eligible for a federally mandated product many insurance companies must offer. If you meet the following requirements, check with BCBSNC or another insurance carrier to see if you qualify:

- The applicant has 18 or more months of prior CREDITABLE COVERAGE
- The applicant's most recent coverage was group coverage
- The applicant is not eligible for Medicare or another group health insurance plan.

Certificate Of Creditable Coverage

BCBSNC or its designee will supply a Certificate of Creditable Coverage when your or your DEPENDENT'S coverage under the health benefit plan ends or you exhaust continuation of coverage. Keep the Certificate of Creditable Coverage in a safe place. It may help you receive credit toward any new PRE-EXISTING CONDITIONS waiting period that applies on subsequent coverage. You may request a Certificate of Creditable Coverage from BCBSNC Customer Service while you are still covered under this health benefit plan and up to 24 months following your termination. You may call BCBSNC Customer Service at 1-877-258-3334 (toll-free), Monday through Friday 8:00 a.m. - 6:00 p.m. except holidays.

Termination Of MEMBER Coverage

A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends.

Termination For Cause

A MEMBER'S coverage may be terminated upon 31 days prior written notice for the following reasons:

- The MEMBER fails to pay or to have paid on his or her behalf or to make arrangements to pay any deductible or coinsurance for services covered under the health benefit plan
- No IN-NETWORK PROVIDER is able to establish or maintain a satisfactory DOCTOR-patient relationship with a MEMBER, as determined by BCBSNC
- A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

As an alternative to termination as stated above, BCBSNC, in its sole discretion, may limit or revoke a MEMBER'S access to certain IN-NETWORK PROVIDERS.

A MEMBER'S coverage will be terminated immediately by BCBSNC for the following reasons:

- Fraud or material misrepresentation by the EMPLOYEE or DEPENDENT
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this health benefit plan, or uses another person's ID CARD.

To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under your health benefit plan unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums.

Rights And Responsibilities Under The UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's denial of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a final determination of all denials of service that were based upon MEDICAL NECESSITY
- Request a review of denial of benefit coverage through our GRIEVANCE process
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a health care service is needed
- Limit what we request from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with North Carolina law and your health benefit plan.

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

Prospective Review/PRIOR REVIEW

BCBSNC requires that certain health care services receive PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called prospective reviews. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in a partial or full denial of benefits. The list of services that require PRIOR REVIEW may change from time to time.

> General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for a detailed list of these services.

If the requested CERTIFICATION is denied, you have the right to appeal. See "What If You Disagree With Our Decision?" for more information. Certain services may not be covered OUT-OF-NETWORK. See "COVERED SERVICES."

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your PROVIDER of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if more information is needed. BCBSNC will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a

decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the PROVIDER by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT'S life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your PROVIDER of its decision within 72 hours after receiving the request. If BCBSNC needs more information to process your expedited review, BCBSNC will notify you and your PROVIDER of the information needed as soon as possible but no later than 24 hours after we receive your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours.

An expedited review may be requested by calling BCBSNC Customer Service at the number given in "Whom Do I Contact?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the HOSPITAL or other facility within three business days after BCBSNC receives all necessary information, but no later than 15 days after the request. If BCBSNC does not provide CERTIFICATION of a health care service, BCBSNC will notify you, your HOSPITAL'S or other facility's UM department and your PROVIDER. Written confirmation of the decision will also be sent to your home by U.S. mail.

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

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT'S life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your PROVIDER of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

BCBSNC also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this health benefit plan. BCBSNC may take an extension of up to 15 days if more information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed, and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under your health benefit plan due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management), encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and BCBSNC to work together to meet the individual's health needs and promote quality outcomes. To accomplish

this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. BCBSNC is not obligated to provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for an ongoing special condition at the IN-NETWORK benefit level when you or your EMPLOYER changes health benefit plans or when your PROVIDER is no longer in the Blue Options network. If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition that meets our continuity of care criteria, BCBSNC will notify you 30 days before the PROVIDER'S termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, you must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by BCBSNC's requirements for continuity of care. An 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, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the MEMBER'S life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the PROVIDER, except in the cases of:

- scheduled SURGERY, organ transplantation, or inpatient care which shall extend through the date of discharge and post-discharge follow-up care or other inpatient care occurring within 90 days of the date of discharge; and
- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the IN-NETWORK benefit level. Continuity of care will not be provided when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

> Please call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for more information.

Further Review Of UTILIZATION MANAGEMENT Decisions

If you receive a NONCERTIFICATION as part of the PRIOR REVIEW process, you have the right to request that BCBSNC review the decision through the GRIEVANCE process. See "What If You Disagree With Our Decision?"

Delegated UTILIZATION MANAGEMENT

BCBSNC delegates UM and the first level GRIEVANCE review for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Claims determinations and second level GRIEVANCE review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow us to determine the best services and products to offer our MEMBERS. They also help us keep pace with the ever-advancing medical field. Before implementing any new or revised policies, we review professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. We then seek additional input from PROVIDERS who know the needs of the patients they serve.

In addition to the UM program, BCBSNC offers a GRIEVANCE procedure for our MEMBERS. GRIEVANCES include dissatisfaction with a claims denial or any of our decisions (including an appeal of a NONCERTIFICATION decision), policies or actions related to the availability, delivery or quality of health care services. If you have a GRIEVANCE, you have the right to request that BCBSNC review the decision through the GRIEVANCE process. The GRIEVANCE process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The GRIEVANCE Process

For each step in this process, there are specified time frames for filing a GRIEVANCE and for notifying you or your PROVIDER of the decision. The review must be requested in writing, within 180 days of a NONCERTIFICATION or denial of benefit coverage (the initial claim denial or the first level GRIEVANCE review decision).

Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'S name
- Patient's name
- The nature of the GRIEVANCE
- Any other information that may be helpful for the review.

> To request a form to submit a request for review, visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

All correspondence related to a request for a review through BCBSNC's GRIEVANCE process should be sent to:
BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

In addition, MEMBERS may also receive assistance with GRIEVANCES from the Managed Care Patient Assistance Program by contacting:
Managed Care Patient Assistance Program
Consumer Protection Division, Office of the Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001
Fax: 1-919-733-6276
Tel: 1-919-733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the GRIEVANCE, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level GRIEVANCE Review

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

Although you are not allowed to attend a first level GRIEVANCE review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a

reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level GRIEVANCE Review

Since your health benefit plan is subject to ERISA, the first level GRIEVANCE review is the only level that you must complete before you can pursue your GRIEVANCE in an action in federal court.

Otherwise, if you are dissatisfied with the first level GRIEVANCE review decision, you have the right to a second level GRIEVANCE review. Second level GRIEVANCES are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level GRIEVANCE review, the following information will be given to you:

- Name, address and telephone number of the GRIEVANCE coordinator
- A statement of your rights, including the right to:
  - request and receive from us all information that applies to your case
  - attend the second level GRIEVANCE review meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
  - pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level GRIEVANCE review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your GRIEVANCE even if you do not attend the meeting. A written decision will be issued to you within seven business days of the review meeting.

If you have insurance-related problems or questions at any stage in the review process, you may contact the North Carolina Department of Insurance for assistance. Inquiries may be directed by calling 1-800-546-5664 or by writing to the:
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level GRIEVANCE or the second level GRIEVANCE review, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Expedited Review

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion

of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level GRIEVANCE review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing. After requesting an expedited review, BCBSNC will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

External Review

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

- a NONCERTIFICATION decision, or
- an appeal decision upholding a NONCERTIFICATION decision, or
- a second level GRIEVANCE decision upholding a NONCERTIFICATION decision.

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

- your request is about a MEDICAL NECESSITY determination that resulted in a NONCERTIFICATION;
- you had coverage with BCBSNC when the NONCERTIFICATION was issued;
- the service for which the NONCERTIFICATION was issued appears to be a COVERED SERVICE; and
- you have exhausted BCBSNC's internal GRIEVANCE review process as described below.

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

- completed BCBSNC's first and second level GRIEVANCE review and received a written second level determination from BCBSNC, or
- filed a second level GRIEVANCE and have not requested or agreed to a delay in the second level GRIEVANCE process, but have not received BCBSNC's written decision within 60 days of the date you can show that the GRIEVANCE was filed with BCBSNC, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeal and/or second level GRIEVANCE process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective NONCERTIFICATION (a NONCERTIFICATION which occurs after you have already received the services in question), the 60-day time limit for receiving BCBSNC's second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second level determination from BCBSNC.

Expedited External Review

An expedited external review may be available if the time required to complete either an expedited internal first or second level GRIEVANCE review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- a NONCERTIFICATION from BCBSNC and have filed a request with BCBSNC for an expedited first level appeal; or
- a first level appeal decision upholding a NONCERTIFICATION and have filed a request with BCBSNC for an expedited second level GRIEVANCE review; or
- a second level GRIEVANCE review decision from BCBSNC.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first level appeal or second level GRIEVANCE decision concerning a NONCERTIFICATION of the admission, availability of care, continued stay or EMERGENCY health care services.

If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if you have exhausted the internal GRIEVANCE review process; or (2) require the completion of the internal GRIEVANCE review process and another request for an external review. An expedited external review is not available for retrospective NONCERTIFICATIONS.

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

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

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

(In Person)
North Carolina Department of Insurance
Dobbs Building
430 N. Salisbury Street, Suite 4105
Raleigh, NC 27603
Tel: (919) 807-6860
Tel (toll free in NC): (877)-885-0231

(Web): www.ncdoi.com for external review information and request form

The Healthcare Review Program provides consumer counseling on utilization review and GRIEVANCE issues.

Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your PROVIDER of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BCBSNC upholding a NONCERTIFICATION (generally the notice of a second level GRIEVANCE review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BCBSNC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial NONCERTIFICATION to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the NONCERTIFICATION appeal decision or the second level GRIEVANCE review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:
Blue Cross Blue Shield of North Carolina
Appeals Department
HQ2540HM
PO Box 30055
Durham, NC 27702-3055

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

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within four business days) of the date the NCDOI received your external review request. If the IRO's decision is to reverse the NONCERTIFICATION, BCBSNC will, within three business days (or, for an expedited review, within one day) of receiving notice of the IRO's decision, reverse the NONCERTIFICATION decision and provide coverage for the requested service or supply. If you are no longer covered by BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the NONCERTIFICATION, BCBSNC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

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

Delegated Appeals

BCBSNC delegates responsibility for the first level GRIEVANCE review for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Please forward written GRIEVANCES to:
Magellan Behavioral Health
Appeals Department
PO Box 1619
Alpharetta, GA 30009

Second level GRIEVANCE review is provided by BCBSNC.

Benefits To Which MEMBERS Are Entitled

The only legally binding benefits are described in this benefit booklet, which is part of the GROUP CONTRACT between BCBSNC and your EMPLOYER. The terms of your coverage cannot be changed or waived unless BCBSNC agrees in writing to the change.

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits and the right to receive payment cannot be transferred to another person. At the option of BCBSNC, payment for services will be made to the PROVIDER of the services, or BCBSNC may choose to pay the SUBSCRIBER.

If a MEMBER resides with a custodial parent or legal guardian who is not the SUBSCRIBER, BCBSNC will, at its option, make payment to either the PROVIDER of the services or to the custodial parent or legal guardian for services provided to the MEMBER. If the SUBSCRIBER or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in this health benefit plan will be provided only for services and supplies that are performed by a PROVIDER as specified in this health benefit plan and regularly included in the ALLOWED AMOUNT. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under this health benefit plan.

Any amounts paid by BCBSNC for noncovered services or that are in excess of the benefit provided under your Blue Options HSA coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER'S future claims payments. This can result in a reduction or elimination of future claims payments. BCBSNC will recover amounts we have paid for work-related accidents, injuries, or illnesses covered under state workers' compensation laws upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

PROVIDERS are independent contractors, and they are solely responsible for injuries and damages to MEMBERS resulting from misconduct or negligence**.**

BCBSNC's Disclosure Of Protected Health Information (PHI)

At BCBSNC, we take your privacy seriously. We handle all PHI as required by state and federal laws and regulations and accreditation standards. We have developed a privacy notice that explains our procedures.

> To obtain a copy of the privacy notice, visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning eligibility for benefits, coverage of services, care, treatment, or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations.

PROVIDER Reimbursement

BCBSNC has contracts with certain PROVIDERS of health care services for the provision of, and payment for, health care services provided to all MEMBERS entitled to health care benefits. BCBSNC's payment to PROVIDERS may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from BCBSNC greater than the charges for services provided to an eligible MEMBER, or BCBSNC may pay less than charges for services, due to negotiated contracts. The MEMBER is not entitled to receive any portion of the payments made under the terms of contracts with PROVIDERS. The MEMBER'S liability when defined as a percent of charge shall be calculated based on the lesser of the ALLOWED AMOUNT or the PROVIDER'S billed charge for COVERED SERVICES provided to a MEMBER.

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options HSA MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Blue Options HSA ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside Of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Programs." As a MEMBER of BCBSNC, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of BCBSNC. While BCBSNC maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

Whenever you obtain health care services outside the area in which the BCBSNC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between BCBSNC and other Blue Cross and/or Blue Shield licensees.

Under the BlueCard Program, the amount you pay toward such COVERED SERVICES, such as deductibles, copayments or coinsurance, is usually based on the **lesser** of:

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the Host Blue passes on to us.
  This "negotiated price" can be:
  - A simple discount that reflects the actual price paid by the Host Blue to your PROVIDER
  - An estimated price that factors in special arrangements with your PROVIDER or with a group of PROVIDERS and may include types of settlements, incentive payments, and/or other credits or charges
  - An average price, based on a discount that reflects the expected average savings for similar types of health care PROVIDERS after taking into account the same types of special arrangements as with an estimated price.

  The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, such adjustments will not affect the price that BCBSNC uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard Program method or requires a surcharge, your required payment for services in the state will be based upon the method required by that state's law.

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the negotiated price made available to BCBSNC by the Host Blue.

If you receive COVERED SERVICES from a non-participating PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue's non-participating PROVIDER local payment or the pricing arrangements required by applicable state law. However, in certain situations, BCBSNC may use other payment bases, such as billed charges, to determine the amount BCBSNC will pay for COVERED SERVICES from a non-participating PROVIDER. In any of these situations, you may be liable for the difference between the non-participating PROVIDER'S billed amount and any payment BCBSNC would make for the COVERED SERVICES.

Notice Of Claim

BCBSNC will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER INCURS the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of receipt of a notice of claim if the MEMBER has financial liability on the claim. BCBSNC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, we will notify the MEMBER or the MEMBER'S authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet sections on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed

- A description of the review procedures and the time limits applicable to such procedures, including the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the MEMBER'S medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving URGENT CARE, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a GRIEVANCE with BCBSNC. See "What If You Disagree With Our Decision?" for more information.

Limitation Of Actions

Since your health benefit plan is subject to ERISA, you must only exhaust the first level GRIEVANCE review process following the Notice of Claim requirement. Please see "What If You Disagree With Our Decision?" for details regarding the GRIEVANCE review process. No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level GRIEVANCE review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, BCBSNC may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. COB is explained in more detail in the GROUP CONTRACT between your EMPLOYER and BCBSNC; however, the rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for group health insurance coverage.

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	√	
	The plan with COB is		√
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a dependent is		√
The person is covered as a dependent child under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is	√	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The noncustodial parent's plan is		√
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
(Note: You may be required to submit a copy of the court order or legal documentation in this instance.)	*Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are*	√	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	√	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		√
	Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√

NOTE: If either the primary or the secondary plan covers a particular service, where BCBSNC is the secondary plan, BCBSNC will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service. BCBSNC may request information about the other plan from the MEMBER. A prompt reply will help us process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for COVERED SERVICES are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

Programs Outside Your Regular Benefits

BCBSNC may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Opportunities to qualify for gift items (such as exercise equipment and clothing) based on submitting activity diaries that record wellness and exercise activities or preventive health behaviors
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

BCBSNC may not provide these discounts on goods and services directly, but may instead arrange these for your convenience. These discounts are outside your health plan benefits. BCBSNC is not liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside your health plan benefits. BCBSNC is not liable for third party PROVIDERS' negligent provision of the gifts. BCBSNC may stop or change these programs at any time.

Health Information Services

If you have certain health conditions, BCBSNC or a representative of BCBSNC may contact you to provide information about your condition, answer questions and tell you about resources that may be available to you. Your participation is voluntary, and your medical information will be kept confidential.

ALLOWED AMOUNT
The maximum amount that BCBSNC determines is reasonable for covered services provided to a MEMBER. The allowed amount includes any BCBSNC payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. Except as otherwise specified in "Emergency Care," for PROVIDERS that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by BCBSNC that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where BCBSNC has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or a charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY SURGICAL CENTER
A NONHOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:
a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
c) Does not provide inpatient accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

BENEFIT PERIOD
The period of time, as stated in the "Summary Of Benefits" and GROUP CONTRACT, during which charges for COVERED SERVICES provided to a MEMBER must be INCURRED in order to be eligible for payment by BCBSNC. A charge shall be considered INCURRED on the date the service or supply was provided to a MEMBER.

BENEFIT PERIOD MAXIMUM
The maximum amount of charges or number of visits in a BENEFIT PERIOD that will be covered on behalf of a MEMBER. Services in excess of a benefit period maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

BRAND NAME
The proprietary name of the PRESCRIPTION DRUG that the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging. BCBSNC makes the final determination of the classification of brand name drug products based on information provided by the manufacturer and other external classification sources

CERTIFICATION
The determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy our requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

COMPLICATIONS OF PREGNANCY
Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. EMERGENCY cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL
Existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COSMETIC
To improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a COVERED SERVICE. This also does not include reconstructive SURGERY to correct CONGENITAL or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S)
A service, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of this health benefit plan. Any services in excess of a BENEFIT PERIOD or LIFETIME MAXIMUM are not covered services.

CREDITABLE COVERAGE
Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

DENTAL SERVICE(S)
Dental care or treatment provided by a DENTIST or OTHER PROFESSIONAL PROVIDER in the DENTIST'S office to a covered MEMBER while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST
A dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide DENTAL SERVICES, perform dental SURGERY or administer anesthetics for dental SURGERY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEPENDENT
A MEMBER other than the SUBSCRIBER as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN)
A child under age 26 who is the EMPLOYEE'S biological child, a stepchild who lives with the EMPLOYEE, a legally adopted child (or child placed with the SUBSCRIBER and/or spouse for adoption), a FOSTER CHILD, or any other child for whom legal guardianship has been awarded to SUBSCRIBER and/or spouse.

DEVELOPMENTAL DYSFUNCTION
Difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the MEMBER has not yet attained. Examples include, but are not limited to: speech therapy to teach a MEMBER to talk, follow directions or learn in school; physical therapy to treat a MEMBER with low muscle tone or to teach a MEMBER to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a MEMBER the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.

DOCTOR
Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or SURGERY by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT
Items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

EFFECTIVE DATE
The date on which coverage for a MEMBER begins, according to "When Coverage Begins And Ends."

EMERGENCY(IES)

The sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

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 in the EMERGENCY department.

EMPLOYEE
The person who is eligible for coverage under this health benefit plan due to employment with the EMPLOYER and who is enrolled for coverage.

EMPLOYER
UW Small HSA

ERISA
The Employee Retirement Income Security Act of 1974

EXPERIMENTAL
See INVESTIGATIONAL.

FACILITY SERVICES
COVERED SERVICES provided and billed by a HOSPITAL or NONHOSPITAL FACILITY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

FORMULARY
The list of outpatient PRESCRIPTION DRUGS, insulin, and certain over-the-counter drugs that may be available to MEMBERS.

FOSTER CHILD(REN)
Children under age 18 i) for whom a guardian has been appointed by a clerk of superior court of any county in North Carolina or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

GENERIC
A drug name not protected by a trademark which has the same active ingredient, strength and dosage form, and which is determined by the Food and Drug Administration (FDA) to be therapeutically equivalent to the PRESCRIPTION BRAND NAME drug.

GRIEVANCE
Grievances include dissatisfaction with a claims denial or any of our decisions (including an appeal of a NONCERTIFICATION decision), policies or actions related to the availability, delivery or quality of health care services.

GROUP ADMINISTRATOR
A representative of the EMPLOYER designated to assist with MEMBER enrollment and provide information to SUBSCRIBERS and MEMBERS concerning the health benefit plan.

GROUP CONTRACT
The agreement between BCBSNC and the EMPLOYER. It includes the master group contract, the benefit booklet(s) and any exhibits or ENDORSEMENTS, the group enrollment application and medical questionnaire when applicable.

HOMEBOUND
A MEMBER who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. To be homebound means that leaving home takes considerable and taxing effort. A MEMBER is not considered homebound solely because the assistance of another person is required to leave the home.

HOME HEALTH AGENCY

A NONHOSPITAL FACILITY which is primarily engaged in providing home health care services medical or therapeutic in nature, and which:

a) Provides skilled nursing and other services on a visiting basis in the MEMBER'S home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

HOSPICE

A NONHOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:

a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.

HOSPITAL

An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID card)

The card issued to our MEMBERS upon enrollment which provides group/MEMBER identification numbers, names of the MEMBERS, deductible and coinsurance, and key phone numbers and addresses.

INCURRED

The date on which a MEMBER receives the service, drug, equipment or supply for which a charge is made.

INFERTILITY

The inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

IN-NETWORK

Designated as participating in the Blue Options network. BCBSNC's payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER

A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of MEDICAL SERVICES and supplies that has been designated as a Blue Options PROVIDER by BCBSNC or a PROVIDER participating in the BlueCard program.

INVESTIGATIONAL (EXPERIMENTAL)

The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under this health benefit plan. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.

LICENSED PRACTICAL NURSE (LPN)

A nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

LIFETIME MAXIMUM

The maximum amount of COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under this health benefit plan. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

MAINTENANCE THERAPY
Services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.

MEDICAL SUPPLIES
Health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.

MEDICALLY NECESSARY (or MEDICAL NECESSITY)
Those COVERED SERVICES or supplies that are:
a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under this health benefit plan, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of medical care in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

MEMBER
A SUBSCRIBER or DEPENDENT, who is currently enrolled in this health benefit plan and for whom premium is paid.

MENTAL ILLNESS
(1) when applied to an adult MEMBER, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a DEPENDENT CHILD, a mental condition, other than mental retardation alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-IV"). Mental illness does not include substance-related disorders, SEXUAL DYSFUNCTIONS not due to organic disease, and disorders coded as "V" codes in the DSM-IV.

NONCERTIFICATION
A determination by BCBSNC that a service covered under your health benefit plan has been reviewed and does not meet BCBSNC's requirements for MEDICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY
An institution or entity other than a HOSPITAL that is accredited and licensed or certified in the state where located to provide COVERED SERVICES and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT
Medical care, SURGERY, diagnostic services, SHORT-TERM REHABILITATIVE THERAPY services and MEDICAL SUPPLIES provided in a PROVIDER'S office.

OTHER PROFESSIONAL PROVIDER
A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER
An institution or entity other than a DOCTOR or HOSPITAL, which is accredited and licensed or certified in the state where located to provide COVERED SERVICES and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES)

The following services and supplies, both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote recovery from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed in the state of practice.

a) Cardiac rehabilitative therapy - reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) - the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)
c) Dialysis treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy - programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy - the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy - introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK
Not designated as participating in the Blue Options network, and not certified in advance by BCBSNC to be considered as IN-NETWORK. Our payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER
A PROVIDER that has not been designated as a Blue Options PROVIDER by BCBSNC.

OUTPATIENT CLINIC(S)
An accredited institution/facility associated with or owned by a HOSPITAL. An outpatient clinic may bill for outpatient visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the Outpatient Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

POSITIONAL PLAGIOCEPHALY
The asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

PRE-EXISTING CONDITION
A condition, disease, illness or injury for which medical advice, diagnosis, care or treatment was received or recommended within the 6-month period prior to your enrollment date. Pregnancy and genetic information are not considered pre-existing conditions.

PRESCRIPTION
An order for a drug issued by a DOCTOR duly licensed to make such a request in the ordinary course of professional practice; or requiring such an order.

PRESCRIPTION DRUG
A drug that has been approved by the Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: Federal law prohibits dispensing without PRESCRIPTION," or labeled in a similar manner, and is appropriate to be administered without the presence of a medical supervisor. Prescription drugs include:

a) Insulin
b) Self-administered injectable drugs
c) Contraceptive devices
d) Select diabetic supplies: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

PREVENTIVE CARE
MEDICAL SERVICES provided by or upon the direction of a DOCTOR or OTHER PROVIDER related to the prevention of disease.

PRIMARY CARE PROVIDER (PCP)
An IN-NETWORK PROVIDER who has been designated by BCBSNC as a PCP.

PRIOR REVIEW
The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies,

appropriateness, health care setting, or level of care and effectiveness. Prior review results in CERTIFICATION or NONCERTIFICATION of benefits.

PROSTHETIC APPLIANCES
Fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.

PROVIDER
A HOSPITAL, NONHOSPITAL FACILITY, DOCTOR, or OTHER PROVIDER, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

REGISTERED NURSE (RN)
A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

RESPITE CARE
Services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities. Respite care is provided in-home or at an alternative location for a short stay. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

ROUTINE FOOT CARE
Hygiene and preventive maintenance of feet such as trimming of corns, calluses or nails that do not usually require the skills of a qualified PROVIDER of foot care services.

SEXUAL DYSFUNCTION
Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SHORT-TERM REHABILITATIVE THERAPY
Services and supplies both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote the recovery of the MEMBER from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational Therapy - treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical Therapy - treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
c) Speech Therapy - treatment for the restoration of speech impaired by disease, SURGERY, or injury; or certain significant physical CONGENITAL conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY
A NONHOSPITAL FACILITY licensed under state law that provides skilled nursing, rehabilitative and related care where professional MEDICAL SERVICES are administered by a registered or LICENSED PRACTICAL NURSE. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST
A DOCTOR who is recognized by BCBSNC as specializing in an area of medical practice.

SPECIALTY DRUG(S)
Those medications classified by BCBSNC that generally have unique indications or uses, or require special dosing or administration, or are typically prescribed by a SPECIALIST, or are significantly more expensive than alternative therapies.

STABILIZE
To provide medical care that is appropriate to prevent a material deterioration of the MEMBER'S condition, within reasonable medical certainty.

SUBSCRIBER

The person who is eligible for coverage under this health benefit plan due to employment and who is enrolled for coverage.

SURGERY
The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:
a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

TOTAL OUT-OF-POCKET MAXIMUM
The maximum amount listed in the "Summary Of Benefits" that is payable by the MEMBER in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. It includes deductible and coinsurance.

URGENT CARE
Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM)
A set of formal processes that are used to evaluate the MEDICAL NECESSITY, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, PROVIDERS and facilities.

WAITING PERIOD
The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of this health benefit plan.

BCBSNC Web Site

To view your claims, get benefit information, claim forms, health and wellness information, drug FORMULARY updates, find a DOCTOR, change your address, and request new ID CARDS, we invite you to visit our Web site: **bcbsnc.com**

BCBSNC Customer Service

For questions about your benefits or claims, ID CARD requests, or to voice a complaint:
BCBSNC Customer Service.....1-877-258-3334 (toll free)

Mental Health And Substance Abuse Services

BCBSNC delegates the administration of these benefits to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact this vendor directly and request PRIOR REVIEW for inpatient and outpatient services, except for OFFICE VISIT services and in EMERGENCIES. In the case of an EMERGENCY, please notify the vendor as soon as reasonably possible:
Magellan Behavioral Health.....1-800-359-2422 (toll free)

Out Of North Carolina Care

For help obtaining care outside of North Carolina and outside of the U.S., visit our national Web site at **bcbs.com** or call:

BlueCard® PPO Program.....1-800-810-2583 (toll free)

HealthLine Blue℠

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:
HealthLine Blue.....1-877-477-2424 (toll free)

PRIOR REVIEW

Some services require PRIOR REVIEW and CERTIFICATION by BCBSNC. The list of these services may change from time to time. Please visit our Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed above for current information about which services require PRIOR REVIEW. See "Prospective Review/PRIOR REVIEW" in "UTILIZATION MANAGEMENT" for information about the review process. To request PRIOR REVIEW, call:

PROVIDERS.....1-800-672-7897 (toll free)
MEMBERS.....1-877-258-3334 (toll free)

INFORMATION ABOUT YOUR HEALTH SAVINGS ACCOUNT (HSA)

The product offered by BCBSNC is a High Deductible Health Plan (HDHP) that is intended to be paired with a Health Savings Account (HSA). The HSA is not part of this health benefit plan administered by BCBSNC. The HSA is administered separately, through a company that is not affiliated with BCBSNC. Your rights with respect to the HSA are governed by a separate agreement with the HSA custodian. While BCBSNC may forward certain materials to you on behalf of the HSA custodian, BCBSNC assumes no responsibility for the administration of the HSA. Termination of your HDHP with BCBSNC does not terminate your HSA with the HSA custodian.

Your HDHP can qualify you, or someone else on your behalf, to contribute to a HSA, unless you are otherwise ineligible under applicable federal requirements. You must be covered under an HDHP to contribute, or have someone else contribute on your behalf, to an HSA. Factors that may make you ineligible to have contributions made to your HSA include, but may not be limited to, whether you are covered directly or as a dependent on other, disqualifying health coverage (including other health funds), whether you can be claimed as a dependent on another person's tax return, and whether you are enrolled in Medicare. In addition, the Tax Code limits the amount that may be contributed to an HSA. Even if BCBSNC collects information from you that may indicate your ineligibility to contribute to an HSA, or that may indicate your contribution limit, BCBSNC will not make these determinations, and it is your responsibility to do so. If you are unsure, please consult a qualified tax advisor.

Some expenses may not qualify for reimbursement under the Tax Code. Some dependents may not qualify as dependents for purposes of reimbursement from your fund. It is your responsibility to determine which, if any, of your and your dependents' medical expenses qualify for reimbursement from your HSA fund. If you are unsure, please consult a qualified tax advisor.

Some or all administrative fees for your HSA may be waived during your coverage under Blue Options HSA. If this coverage with BCBSNC terminates and you elect to retain your HSA, the HSA custodian may then begin collecting all administrative fees directly from you under the terms and conditions established between you and the HSA custodian.

If you have been issued a debit card in connection with your HSA, the following applies. The debit card is issued by the bank chosen by your HSA custodian. Although BCBSNC's name and marks may be included on the face of the debit card for your convenience, BCBSNC is not responsible or liable for administration of your debit card. The terms and conditions associated with your debit card are governed by your agreement with the bank issuing the card. It is your responsibility to ensure that the card is used only for qualified medical expenses. If you are unsure about whether an expense is a qualified medical expense, please consult a qualified tax advisor.

IMPORTANT NOTICE

LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. *And, as noted in the box below*, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina, 27605

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

1. The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
2. Except as provided in (3) and (4) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
3. The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
4. The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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Group Effective Date:
August 1, 2011

BlueCross BlueShield of North Carolina

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