Benefit Booklet
For

BlueValue℠

Benefit Booklet

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet, along with the "Summary Of Benefits," application, and any optional benefit endorsement, is the legal contract between you and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

A summary of benefits, conditions, limitations, and exclusions is set forth in this benefit booklet for easy reference.

YOUR POLICY MAY NOT BE IN FORCE WHEN YOU HAVE A CLAIM! PLEASE READ!

Your policy was issued based on the information entered in your application, a copy of which is attached to the policy. If, to the best of your knowledge and belief, there is any misstatement in your application or if any information of any insured person has been omitted, you should advise BCBSNC immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

RIGHT TO RETURN POLICY WITHIN 10 DAYS. If for any reason you are not satisfied with your policy, you may return it to BCBSNC within 10 days of the date you received it, and the premium you paid will be promptly refunded.

Blue Value MEMBER'S premiums may be adjusted with 30 days notice. After the first premium adjustment, the premium cannot be adjusted more frequently than 12 months, unless an adjustment is required by law or you make changes to your policy. Premiums may increase as you age, and you will be notified within 30 days notice of any rate increase.

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: J. Bradley Wilson

President

Secretary

Important Cancellation Information–please read the provision in this benefit booklet entitled, "When Coverage Begins And Ends."

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GETTING STARTED WITH BLUE VALUE

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN:

This health benefit plan was purchased through the Health Insurance MARKETPLACE (MARKETPLACE) established through the federal health care reform legislation called the Patient Protection and Affordable Care Act. In order for a health insurance plan to be offered in the MARKETPLACE it must meet the requirements of a qualified health plan (QHP) which include coverage of a core set of benefits, called ESSENTIAL HEALTH BENEFITS, and certain limits on deductibles, copayments, and out-of-pocket costs. See "Glossary" for a list of the services that are considered ESSENTIAL HEALTH BENEFITS. Note that while no annual or lifetime dollar limits are allowed on ESSENTIAL HEALTH BENEFITS, federal law does allow insurance companies to include annual or lifetime dollar limits on non-essential health benefits. See "Summary of Benefits" for any limits that may apply.

By purchasing health insurance through the MARKETPLACE and depending on your household income, you may be eligible for federal subsidies, including a new type of tax credit that you can use to lower your monthly health insurance premium (called a premium subsidy) and/or financial assistance on out-of-pocket expenses, called cost-sharing reductions. In certain situations, the federal government no longer offers a premium subsidy once an individual qualifies for health benefits under the Medicare program. However, the rules that apply to such situations are complex. If you have questions about how your Medicare eligibility might affect the subsidy you are receiving, you should contact the MARKETPLACE. Find out more at **www.healthcare.gov**.

In accordance with applicable federal law, BCBSNC will not discriminate against any health care provider acting within the scope of their license or certification, or against any person who has received federal subsidies, or taken any other action to endorse his or her right under applicable federal law. Further, BCBSNC shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the "Glossary":

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them, if this health benefit plan includes copayments. One copayment covers most services at a PROVIDER'S office. Copayments may also apply to URGENT CARE and emergency room services. Copayments are not credited to the deductible; however, they are credited to the TOTAL OUT-OF-POCKET LIMIT.
Deductible	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under this health benefit plan. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services. This health benefit plan has an embedded deductible which means you have an individual deductible and if DEPENDENTS are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under this

	health benefit plan. However, once the family deductible is met, it is met for all covered family MEMBERS, regardless of whether your individual deductible is met. Please see PREVENTIVE CARE in "COVERED SERVICES" for PREVENTIVE CARE services that are covered even before the deductible is met unless otherwise noted. Amounts applied to the deductible will count towards any visit or day maximums for those services.
Coinsurance	The sharing of charges by BCBSNC and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. Amounts applied to your deductible and coinsurance, as well as any applicable copayments, count towards your TOTAL OUT-OF-POCKET LIMIT. The TOTAL OUT-OF-POCKET LIMIT does not include charges over ALLOWED AMOUNTS, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums, and charges for noncovered services. If you have more than one health insurance plan, amounts paid by the other health insurance plan will not apply to the TOTAL OUT-OF-POCKET LIMIT for this health benefit plan. Your TOTAL OUT-OF-POCKET LIMIT is determined by your type of coverage. This health benefit plan has an individual TOTAL OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family TOTAL OUT-OF-POCKET LIMIT. Once the family TOTAL OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS.

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	$3,825	$4,250
C. Deductible Amount (For IN-NETWORK and OUT-OF-NETWORK Services Combined)	**$1,000**	**$3,000**
D. ALLOWED AMOUNT Minus Deductible (B-C)	$2,825	$1,250
E. Your Coinsurance Amount (x% times D)	**(20%) $565**	**(50%) $625**
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)	**$1,565**	**$4,375**

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

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 appears 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.

Aviso Para Afiliados Que No Hablan Inglés

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios con el plan médico que ha seleccionado. Si tiene alguna dificultad en entender alguna sección de este manual, por favor comuníquese con el Departamento de Servicio al Cliente al número telefónico que aparece en el respaldo de su tarjeta de afiliado (marque 8 para español). Este manual de beneficios está disponible en español en Blue Connect.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

BCBSNC Website: www.bcbsnc.com	Find a network PROVIDER by location or specialty, get information about top-performing facilities, access PRESCRIPTION DRUG information, and information and news about BCBSNC.
Blue Connect **Website: BlueConnectNC.com**	Use our secure website that reflects your specific benefits and information to verify benefits and eligibility, check claims status, download claim and other forms, manage your account, request new ID CARDS, get helpful wellness information and more.
BCBSNC Customer Service: 1-888-206-4697	For questions regarding your benefits, claims inquiries, and new ID CARD requests, or to voice a complaint.
PRESCRIPTION DRUG Information: 1-888-206-4697 or **www.bcbsnc.com/umdrug**	You may visit our website or call BCBSNC Customer Service to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to prior review, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit **www.bcbsnc.com/umdrug** for more information.
MARKETPLACE: 1-800-318-2596 **www.healthcare.gov**	For questions regarding your enrollment in health insurance plans offered through the Federal Health Insurance MARKETPLACE (MARKETPLACE). The MARKETPLACE can answer questions about your eligibility status and subsidies.
PRIOR REVIEW and CERTIFICATION: MEMBERS call: 1-888-206-4697 PROVIDERS, call: 1-800-214-4844	Some services require PRIOR REVIEW and CERTIFICATION from BCBSNC before they are considered for coverage. The list of these services may change from time to time. Current information about which services require PRIOR REVIEW can be found online at **BlueConnectNC.com**.
Magellan Behavioral Health: 1-800-359-2422	For mental health and substance abuse services, BCBSNC delegates the administration of these benefits by contract to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact Magellan Behavioral Health directly and request PRIOR REVIEW for inpatient and certain outpatient services, except in EMERGENCIES. In the case of an EMERGENCY, please notify Magellan Behavioral Health as soon as possible.
Out of North Carolina Care: 1-800-810-2583 (BLUE)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.bcbs.com**.
Health Line Blue℠: 1-877-477-2424	Talk to a nurse 24/7 to receive timely information and advice on a number of health-related issues. Nurses are available by phone in both English and Spanish.
Condition Care Maternity: 1-855-301-2229 (BABY)	Speak one-on-one with a specialized maternity nurse for the support you need. The 24/7 BabyLine® can provide information about programs and support for managing your pregnancy.
Healthy Outcomes Customer	Talk with a representative to receive assistance with any technical issues with

WHO TO CONTACT? *(cont.)*

Service: 1-877-719-9004	the website including navigation, and browser compatibility as well as questions about the Healthy Outcomes program.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical and pediatric dental or vision claims to this address.
PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: BCBSNC PO Box 14501 Lexington, KY 40512-4501	Mail completed PRESCRIPTION DRUG claims to this address.

Value-Added Programs

Please note: These programs are not covered benefits and are outside of this health benefit plan. BCBSNC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. BCBSNC may change or discontinue these programs at any time.

Chiropractic Services 1-888-206-4697	For information about discounts on chiropractic services and a practitioner directory, call or visit **BlueConnectNC.com**.
TruHearing℠ 1-877-343-0745 1-800-975-2674 (TTY toll-free)	For information about discounts on hearing aids, call or visit **BlueConnectNC.com**.
Blue365™ 1-855-511-2583 (BLUE)	Health and wellness information support and services, and special member savings available 365 days a year.
Davis Vision® 1-888-897-9350	For information about discounts on corrective laser eye surgery, call or visit **BlueConnectNC.com**.

HOW BLUE VALUE WORKS

As a MEMBER of the Blue Value plan, you will enjoy quality health care from a network of health care PROVIDERS. You do not have to get a referral to see your DOCTOR and you will have easy access to SPECIALISTS. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER. Although Blue Value has a smaller network, you still have access to IN-NETWORK PROVIDERS, as well as OUT-OF-NETWORK PROVIDERS – the main difference will be the cost to you. Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by BCBSNC as eligible. **NOTE: Blue Value has a smaller PROVIDER network, so not all PROVIDERS participate with all BCBSNC plans.** For a list of eligible PROVIDERS, please visit our website at **www.bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Here's 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 Blue Value program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard® Program. See the "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. 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 website at **www.bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to Contact?"	OUT-OF-NETWORK PROVIDERS are not designated as a Blue Value PROVIDER by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."
AMERICAN INDIAN/ALASKA NATIVE PROVIDERS	If you are eligible to receive care from an AMERICAN INDIAN/ALASKA NATIVE PROVIDER and are a MEMBER who has been designated by the MARKETPLACE to be American Indian/Alaska Native, you and your AMERICAN INDIAN/ALASKA NATIVE PROVIDER are subject to all terms and requirements set forth in this booklet, including but not limited to filing claims and PRIOR REVIEW requirements.	
ALLOWED AMOUNT	If the billed amount for COVERED	You may be responsible for paying any

HOW BLUE VALUE WORKS *(cont.)*

vs. Billed Amount	SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and non-covered expenses. (See Filing Claims below for additional information.)	charges over the ALLOWED AMOUNT in addition to any applicable copayment, deductible, coinsurance, non-covered expenses and CERTIFICATION penalty amounts, if any.
After-hours Care	If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Referrals	BCBSNC does not require you to obtain referrals. However, in order for MEMBERS who are designated by the MARKETPLACE to be American Indian/Alaska Native to receive cost sharing adjustments from PROVIDERS other than AMERICAN INDIAN/ALASKA NATIVE PROVIDERS, BCBSNC may require you to obtain a referral.	
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 benefit level.	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 are responsible for requesting PRIOR REVIEW when necessary. IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans' Affairs (VA) and military PROVIDERS, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina, **you** are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC even if you see an IN-NETWORK PROVIDER. For inpatient and certain 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.	You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER, in or outside of North Carolina, requests PRIOR REVIEW by BCBSNC or its designee when necessary. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance abuse services and all other medical services. Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied. However,

HOW BLUE VALUE WORKS *(cont.)*

	PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy's records do not show you as eligible for coverage, or you are in your three month grace period if you receive a federal subsidy. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. 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 have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Claims must be received by BCBSNC 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.

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 the IN-NETWORK benefit level. 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.

HOW BLUE VALUE WORKS *(cont.)*

For more information, see one of the following sections: "EMERGENCY Care" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC's access to care standards, see our website at **www.bcbsnc.com** and type "access to care" in the search bar. 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 Value 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 website at **www.bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST

PCP to manage your health care. However, 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 needs. 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 **www.bcbsnc.com** and click on 'Find a Doctor' or call BCBSNC Customer Service 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 "Who to Contact?"

Premium Payments

You may view payment information, payment history, and current amount due by visiting our website at

www.bcbsnc.com. Your premiums are due on or before your premium due date. If you pay your premiums through automatic bank draft, please be aware that if there are insufficient funds, BCBSNC may attempt to debit your bank account until sufficient funds are received. We will not make more than three attempts to debit your bank account. BCBSNC does not charge a fee for this service; however, your bank may charge a fee if there are insufficient funds to cover the payment.

If premium payments are not made within the time allowed, this health benefit plan will be terminated. This health benefit plan allows for a 25 day grace period for payment of premiums if you do not receive an Advanced Premium Tax Credit (APTC) or a three month grace period for payment of premiums if you receive an APTC. However, if BCBSNC receives your premiums past the premium due date, BCBSNC may charge a fee for any late payment of premiums. You will be notified if you incur any fees charged by BCBSNC. Failure to pay the fee, either by separate payment or by including the payment with your next premium payment, will result in your next payment being applied first to any outstanding fees incurred and then to your premium payment. This may result in a shortage of monies owed on your premium payment and may result in termination of coverage. See "Termination of MEMBER Coverage."

If premium payments are not made within the time allowed, your health benefit plan will be terminated. If you have been terminated and wish to be reinstated, the following applies:

- You will need to comply with the MARKETPLACE'S requirements regarding enrollment periods. The MARKETPLACE will determine your eligibility.

Please note that premium payments are automatically deposited. BCBSNC's deposit of premiums does not mean an acceptance of coverage. If you have been notified that your coverage is terminated or is scheduled to be terminated, any deposit of premiums by BCBSNC in excess of premiums that are due and owing for the coverage period will not constitute an extension of coverage. BCBSNC will return any excess premium payments. When BCBSNC decides at its sole discretion to accept a late premium payment, BCBSNC will reinstate your coverage back to the date of termination rather than return such premium payment provided that all outstanding fees have been paid.

The MARKETPLACE determines your eligibility for and/or any amount of the Advanced Premium Tax Credit (APTC) that you may be eligible to receive. BCBSNC will only accept APTC information from the MARKETPLACE. For any questions or concerns regarding your eligibility or amount of your APTC, please contact the MARKETPLACE at **www.healthcare.gov** or call the number listed in "Who To Contact?"

COVERED SERVICES

Blue Value 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 "PRIOR REVIEW/Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process, visit our website at www.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 receive, upon request, information about Blue Value, its services and DOCTORS, including a printed copy of this benefit booklet with a benefit summary, and a printed directory of IN-NETWORK PROVIDERS.
- 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 website at **www.bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Office Services

Care you receive as part of an OFFICE VISIT, electronic visit, or house call is covered. This health benefit plan may have a visit limit on PCP OFFICE VISITS, see "Summary of Benefits." PCP OFFICE VISITS in excess of any visit limits are subject to deductible and coinsurance. If applicable, multiple OFFICE VISITS on the same day may result in multiple copayments.

If this health benefit plan has copayments for PCP OFFICE VISITS, a copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

Some DOCTORS or OTHER PROVIDERS may practice in HOSPITAL-based or OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC in "Summary of Benefits."

MEMBERS who receive PRESCRIPTION DRUGS for hemophilia may notice a difference in how these claims are reimbursed. Previously these drugs may have been provided by a physician in an office or outpatient setting and billed to BCBSNC as a medical service. These drugs will be reimbursed as SPECIALTY DRUGS, according to your PRESCRIPTION DRUG benefits. Please see "PRESCRIPTION DRUGS" in the "Summary of Benefits".

> Please check with your PROVIDER before your visit to determine if your PROVIDER will collect deductible and coinsurance, or you can call BCBSNC Customer Service at the number listed in "Who to Contact?" for this information.

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 website at **www.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 that can help you stay safe and healthy.

PREVENTIVE CARE services may fall into three categories: (1) federally-mandated PREVENTIVE CARE services (required to be paid at no cost to you IN-NETWORK); (2) state-mandated PREVENTIVE CARE services (required to be offered both IN and OUT-OF-NETWORK); and (3) non-mandated PREVENTIVE CARE services. In order to determine your benefit, it is important to understand what type of PREVENTIVE CARE service you are receiving, where you are receiving it and why you are receiving it.

Federally-Mandated PREVENTIVE CARE Services

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center at no cost to you. Please log on to our website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, women's PREVENTIVE CARE and certain over-the-counter medications. These over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

The following conditions must be met for these services to be covered at no cost to you IN-NETWORK:

- Services are designated as PREVENTIVE CARE services under federal law (see above website for the most up-to-date information);
- Services are performed by an IN-NETWORK PROVIDER;
- Services are provided in an office-based, outpatient or ambulatory setting or URGENT CARE CENTER; and
- Services are filed with a primary diagnosis of preventive or wellness, and do not include any additional procedures, such as diagnostic services.

Please note that if a particular PREVENTIVE CARE service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided. BCBSNC may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply. Services that would otherwise be excluded under this health benefit plan will be covered at no cost sharing if the criteria mentioned above are met. Visit **www.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a complete list of these federally-mandated PREVENTIVE CARE services that are covered under this health benefit plan.

In certain instances, you may receive PREVENTIVE CARE services that are covered under this health benefit plan; however, these services are subject to your applicable copayment, deductible and coinsurance. The following information will help you determine why you did not receive these services at no cost to you:

Situation	Example	Reason/Result
How your PREVENTIVE CARE service is filed	A colonoscopy includes a primary diagnosis of non-preventive.	Certain PREVENTIVE CARE services will not pay in full because the primary diagnosis filed on the claim is something other than preventive. In this

		instance, the colonoscopy is subject to any applicable copayment, deductible or coinsurance.
Type of PREVENTIVE CARE service	A routine exam includes an additional procedure, such as a urinalysis.	This urinalysis will not pay in full because it is not identified as a federally-mandated PREVENTIVE CARE service. This service is subject to any applicable copayment, deductible or coinsurance.
Place of service (where you receive your PREVENTIVE CARE service)	A mammogram is performed in a setting that is not considered an office, such as a HOSPITAL.	Certain PREVENTIVE CARE services will not be paid in full because they are not performed in an office-based, outpatient or ambulatory setting or URGENT CARE CENTER. In this example, the mammogram is subject to deductible and coinsurance.

Most PREVENTIVE CARE services performed by OUT-OF-NETWORK PROVIDERS are not covered. However, the following list of services is mandated by the state of North Carolina and is available OUT-OF-NETWORK. If you see an OUT-OF-NETWORK PROVIDER for these services, your benefits will be subject to the OUT-OF-NETWORK benefit level.

State-Mandated PREVENTIVE CARE Services:

The following benefits are available IN-NETWORK and OUT-OF-NETWORK:

Bone Mass Measurement Services

This 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. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your benefit level for the location where services are received.

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.

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. Please note that if lab work is done as a result of a colorectal screening exam, the lab work will be covered under your diagnostic benefit and not be considered PREVENTIVE CARE. It will be subject to your benefit level for the location where services are received.

> The PROVIDER search on our website at **BlueConnectNC.com** can help you find office-based PROVIDERS or you can call BCBSNC Customer Service at the number listed in "Who to Contact?" for this information.

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.

Newborn Hearing Screening

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

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.

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.

Screening Mammograms

This 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 BENEFIT PERIOD, 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.

PREVENTIVE CARE Exclusion

- Immunizations required for occupational hazard or international travel.

Obesity Treatment/Weight Management

This health benefit plan provides coverage for OFFICE VISITS for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums. Benefits are also provided for surgical treatment of morbid obesity. Morbid obesity surgical services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Coverage is also provided for PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for long-term use in the treatment of obesity. See "PRESCRIPTION DRUG Benefits"

This health benefit plan also provides benefits for nutritional counseling visits to an IN-NETWORK PROVIDER as part of your PREVENTIVE CARE benefits. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted above.

Obesity Treatment/Weight Management Exclusions

- Removal of excess skin from the abdomen, arms or thighs
- Any costs associated with membership in a weight management program
- Any services not described above.

Ambulance Services

This 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.

This 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 Services Exclusions

- Services provided primarily for the convenience of travel
- Transportation to or from a DOCTOR'S office or dialysis center
- Transportation for the purpose of receiving services that are not considered COVERED SERVICES, even if the destination is an appropriate facility.

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.

Certain Drugs Covered under Your Medical Benefit

This health benefit plan covers certain drugs that must be dispensed under a provider's supervision in an office, outpatient setting, or through home infusion. These drugs are covered under your medical benefit rather than your PRESCRIPTION DRUG benefit. Coverage of some of these drugs may be limited to certain provider settings (such as office, outpatient, or AMBULATORY SURGICAL CENTER). For a list of drugs covered under your medical benefit that are covered only at certain provider settings, visit our website at **www.bcbsnc.com**.

Clinical Trials

This health benefit plan provides benefits for participation in clinical trials phases I, 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 cancer or 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 U.S. 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

- 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

For MEMBERS who are up to age 19 see "Pediatric Dental" for additional dental care benefits. This 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 sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- CONGENITAL deformity, including cleft lip and cleft palate
- Removal of:
  - tumors which are not related to teeth or associated dental procedures
  - cysts which are not related to teeth or associated dental procedures
  - exostoses for reasons other than for preparation for dentures.

This health benefit plan provides benefits 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 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 nine years of age, 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 this 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
- Dental implants

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

- 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. Your benefit depends on where services are received. See "Summary of Benefits."

Diagnostic Services

Diagnostic procedures, such as laboratory studies, sleep 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 laboratory, radiology center, or sample collection device 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.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary of Benefits."

Diagnostic Services Exclusion

- Lab tests that are not ordered by your DOCTOR or OTHER PROVIDER.

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 and accessories 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.

EMERGENCY Care

This 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. PRIOR REVIEW is not required for EMERGENCY SERVICES. If you are

unsure if your condition is an EMERGENCY, you can call Health Line Blue℠, and a Health Line Blue℠ nurse will provide information and support that may save you an unnecessary trip to the emergency room.

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

Situation	Benefit
You go to an IN-NETWORK HOSPITAL emergency room.	Applicable ER copayment, deductible, and/or coinsurance. Multiple visits on the same day may result in multiple ER copayments. PRIOR REVIEW and CERTIFICATION are not required.
You go to an OUT-OF-NETWORK HOSPITAL emergency room.	Benefits paid at the IN-NETWORK level and based on the billed amount. You may be responsible for charges billed separately, which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service and file a claim. PRIOR REVIEW and CERTIFICATION are not required.
You are held for observation.	Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.
You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES.	Inpatient HOSPITAL benefits apply for all COVERED SERVICES received in the emergency room and during hospitalization. PRIOR REVIEW and CERTIFICATION are required for inpatient hospitalization and other selected services following EMERGENCY SERVICES (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an IN-NETWORK HOSPITAL once your condition is stabilized in order to continue receiving IN-NETWORK benefits.
You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged.	Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.

URGENT CARE

This 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 Health Line Blue℠.

FACILITY SERVICES

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NON-HOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NON-HOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NON-HOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the Point of Service network HOSPITAL where he/she practices, unless the 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 for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care" and "EMERGENCY Care." IN-NETWORK PROVIDERS in North

Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. **If PRIOR REVIEW is not requested and CERTIFICATION not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.**

- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined IN- and OUT-OF-NETWORK day maximum per BENEFIT PERIOD. See "Summary of Benefits." PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC in order for services to be covered. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for additional information and any limitations that may apply. If this health benefit plan has an OFFICE VISIT copayment and you change PROVIDERS during pregnancy, terminate coverage during pregnancy, or the pregnancy does not result in delivery, one or more copayments may be charged for prenatal services depending upon how the services are billed by the PROVIDER.

	Mother	Newborn	Payment	
Prenatal care	Care related to the pregnancy before birth.		A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Otherwise, deductible and coinsurance apply for the remainder of maternity care benefits.	
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.")	For the first 48/96 hours, only one BENEFIT PERIOD deductible and admission copayment, if applicable, is required for both mother and baby.	
Post-delivery services	All care for the mother after the	After the first 48/96 hours, whether	If the newborn must remain in 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.	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.	HOSPITAL beyond the mother's prescribed length of stay for any reason, the newborn is considered a sick baby and these charges are subject to the BENEFIT PERIOD deductible if the newborn is added and covered under the policy.	

For information on CERTIFICATION, contact BCBSNC Customer Service at the number listed in "Who to Contact?"

Statement of Rights Under the Newborns' and Mothers' Health Protection Act
Under federal law, health insurance issuers 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. Benefits are provided for a combined IN- and OUT-OF-NETWORK LIFETIME MAXIMUM per MEMBER for each of the specific services listed below associated with three medical ovulation induction cycles, with or without insemination, unless otherwise noted. This LIFETIME MAXIMUM applies to a cumulative number of INFERTILITY treatments with the following services, provided in all places of service.

Service	LIFETIME MAXIMUM
Limited ultrasound for cycle monitoring	24 studies
Estradiol	24 lab tests
Luteinizing Hormone (LH)	24 lab tests
Progesterone	24 lab tests
Follicle Stimulating Hormone (FSH)	24 lab tests
Human Chorionic Gonadotropin (hCG)	8 lab tests
Sperm washing and preparation	3 cycles/treatments
Intrauterine or intracervical insemination	3 cycles/treatments

See "Summary of Benefits" for limitations that apply on ovulation induction cycles. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. For more information about medical policies on INFERTILITY see our website at **www.bcbsnc.com** and search on "infertility", or call BCBSNC Customer Service at the number listed in "Who to Contact?" For information about coverage of PRESCRIPTION DRUGS for INFERTILITY, see "PRESCRIPTION DRUG Benefits."

SEXUAL DYSFUNCTION Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS. Benefits may vary depending on where services are received.

Sterilization

This benefit is available for all MEMBERS. Sterilization includes female tubal occlusion and male vasectomy. Certain sterilization procedures for female MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

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. Certain FDA-approved contraceptive methods for female MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply. See "PRESCRIPTION DRUG Benefits" for coverage of oral contraceptives.

Family Planning Exclusions

- Assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in-vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intra-fallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian transfer (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos

- Surrogate mothers
- Care or treatment of reversal of sterilization
- Elective termination of pregnancy (abortion), except within the first 16 weeks of pregnancy when the life of the mother would be endangered if the unborn child was carried to term or the pregnancy is the result of rape or incest (i.e. abortions for which Federal funding is allowed)
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

Hearing Aids

This health benefit plan 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. When covered, benefits for hearing aids are limited to once every 36 months for MEMBERS under the age of 22. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

HOME HEALTH Care

HOME HEALTH care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, and 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. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. 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. HOME HEALTH care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOME HEALTH Care Exclusions

- Homemaker services, such as cooking and housekeeping
- Dietitian services or meals
- 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. 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 custom-fit for the patient.

Lymphedema-Related Services Exclusions

- 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. See "Summary of Benefits" and "PRESCRIPTION DRUG Benefits."

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on our website at **www.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.

Mental Health and Substance Abuse Services

This 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. Visit our website at **BlueConnectNC.com** or call Magellan Behavioral Health at the number listed in "Who to 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 treatment and RESIDENTIAL TREATMENT FACILITY services also include:

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

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for inpatient services, except for EMERGENCIES. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reducted by 25%, then deductible and coinsurance will be applied.

RESIDENTIAL TREATMENT FACILITY Services

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for mental health and substance abuse services received in a RESIDENTIAL TREATMENT FACILITY. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK RESIDENTIAL TREATMENT FACILITY services, allowed charges will be reduced by 25% then deductible and coinsurance will be applied.

How to Access Mental Health and Substance Abuse Services

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

Inpatient or certain outpatient services may require PRIOR REVIEW and CERTIFICATION, which can be initiated by calling a Magellan Behavioral Health customer service representative at the number listed in "Who to Contact?" Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. The Magellan Behavioral Health customer service representative can help you find an appropriate IN-NETWORK PROVIDER and/or give you information about PRIOR REVIEW and CERTIFICATION requirements.

Mental Health and Substance Abuse Services Exclusion

- Counseling with relatives about a patient.

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 of one device per MEMBER per lifetime.

Orthotic Devices Exclusions

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

COVERED SERVICES *(cont.)*

Pediatric Dental Services

This benefit is only available for MEMBERS up to the end of the month they become age 19.

Preventive and Diagnostic Services

This health benefit plan provides benefits for the following dental preventive services:

- Oral evaluations
  - periodic (twice per BENEFIT PERIOD)
  - comprehensive oral or periodontal (limit one per PROVIDER and one per BENEFIT PERIOD, counts toward periodic frequency limit above)
- Consultations (one per PROVIDER, only covered if no other services except x-rays performed)
- Palliative EMERGENCY treatment for relief of pain only (limit of two per BENEFIT PERIOD)
- Cleaning - prophylaxis, including scaling and polishing above the gum line (twice each BENEFIT PERIOD)
- X-rays
  - full-mouth or panoramic for MEMBERS ages six and older (limited to once every three years unless taken for diagnosis of third molars, cysts, or neoplasms)
  - supplemental bitewings—x-rays showing the back teeth (maximum of four films per BENEFIT PERIOD)
  - vertical bitewings (limit of one set per BENEFIT PERIOD, associated with periodontics)
  - Periapical and occlusal x-ray of a tooth (limited to four films per BENEFIT PERIOD)
  - Extraoral (two films per BENEFIT PERIOD)
- Pulp-testing - evaluation of tooth nerve (limited to one charge per visit, regardless of the number of teeth tested)
- Topical fluoride application to prevent decay (twice each BENEFIT PERIOD)
- Sealants for first and second permanent molars for MEMBERS ages 6 through 15 (one reapplication per tooth every 5 years)
- Space maintainers - devices to keep space from closing after loss of a primary (baby) tooth so a permanent tooth will have room to grow (limited to MEMBERS through age 15, one per tooth per lifetime)
- Diagnostic casts - only if not related to orthodontic or prosthetic services.

Basic and Major Services

This health benefit plan provides benefits for the following basic and major services:

- Routine fillings to restore diseased teeth (limit of one restoration per tooth every two years, unless new decay appears)
  - Amalgam - a soft silver which hardens after it is packed into the cavity
  - Composite resin or other tooth-colored filling materials (limited to what would have been paid for an amalgam)
- Simple extractions
- Stainless steel crowns
  - Primary posterior (one per tooth per lifetime)
  - Primary anterior (one per tooth every three years)
  - Permanent (one per tooth every eight years)
- Pin retention (limit of once per restoration)
- Surgical removal of teeth
- Complex oral surgery
  - Oroantral fistula closure/closure of sinus perforation (once per tooth)
  - Surgical access of unerupted tooth/process to aid eruption (once per tooth)

  - Transseptal fiberotomy **(**once per site every three years)
  - Alveoloplasty (once per site every three years)
  - Vestibuloplasty (once per site every three years)
  - Removal of exostosis (once per site every three years)
  - Incision and drainage of intraoral abscess
  - Frenulectomy (once per site per lifetime)
  - Excision of hyperplastic tissue or pericoronal gingival (once per site every three years)
- Anesthesia limited to deep sedation and intravenous when CLINICALLY NECESSARY and related to covered complex surgery or surgical removal of teeth when three or more quadrants are involved
- Inlays, onlays, crowns (one restoration per tooth every eight years, covered only when a filling cannot restore the tooth)
- Core build-up, cast post and core (one per tooth every eight years)
- Labial veneers, anterior only (one per tooth every five years)
- Complete dentures (once every eight years, no additional allowances for over-dentures or customized dentures)
- Removable partial dentures (once every eight years, no additional allowances for precision or semi-precision attachments)
- Fixed partial dentures (once every eight years, no additional allowances for removable partial dentures)
- Tissue conditioning done more than six months after initial insertion or rebasing or relining (once per 12 months per prosthesis)
- Denture relining done more than six months after the initial insertion (once every two years)
- Rebasing of complete and partial dentures done more than five years after the initial insertion (once every five years)
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures (limited to repairs or adjustments done after 12 months following the initial insertion)
- Replacement of broken teeth on partial or complete denture (once per tooth every three years)
- Recementing of inlays, onlays, crowns and/or fixed partial dentures
- Occlusal guard, for treatment of bruxism only (once every five years)
- Endodontics - treatment of diseases of the nerve chamber and canals
  - Pulpotomy - partial removal of a tooth's pulp and placement of medicament (once per tooth per lifetime)
  - Retrograde filling (limit one per tooth)
  - Root amputation (limit one per tooth)
  - Endodontic therapy (once per lifetime, and retreatment once per lifetime after 12 months from initial treatment)
  - Apexification - inducing root development
  - Hemisection - dividing the crown and roots of a multi-rooted tooth (once per root per lifetime)
  - Apicoectomy - removing the infected tip of the tooth's root **(**once per root per lifetime)
- Periodontics – treatment of the diseases of the gums and bone surrounding the teeth
  - Crown lengthening - reshaping the bone around the teeth to allow for proper prosthetic preparation (once per tooth every three years per site or quadrant)
  - Root planing and periodontal scaling - scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every three years)
  - Full mouth debridement (once every five years)
  - Provisional splinting (once every three years)
  - Periodontal maintenance following active periodontal therapy (twice each BENEFIT PERIOD)
  - Complex surgical periodontal care (limited to one complex surgical periodontal service per area

every three years):

- Gingivectomy and gingivoplasty - cutting out diseased or overgrown gum tissues around the teeth
- Gingival flap procedure - soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue
- Osseous surgery—removing or reshaping the bone around the teeth through an incision of the gum
- Bone replacement graft
- Guided tissue regeneration
- Soft tissue graft/allograft/connective tissue graft
- Distal or proximal wedge

- Placement of dental implants, and any other related implantology services, including pharmacological regimens (limited to once per tooth every eight years).

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered if CLINICALLY NECESSARY. A WAITING PERIOD of 12 months applies for orthodontic services. PRIOR REVIEW and CERTIFICATION are required for certain orthodontic treatment or services will not be covered. The following are COVERED SERVICES and considered part of comprehensive orthodontic care:

- Diagnosis, including the examination, study models, x-rays, and other aids needed to define the problem
- Appliance - a device worn during the course of treatment. Coverage includes the design, making, placement and adjustment of the device. Benefits are not provided to repair or replace an appliance.
- Treatment may include Phase I or Phase II treatment.

Phase I treatment is minor orthodontic treatment and can be paid in one total fee when treatment begins. Phase II treatment is comprehensive orthodontics and is divided into multiple payments.

Pediatric Dental Exclusions

- Anesthesia, except as otherwise covered by this health benefit plan
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability
- Brush biopsy
- Cone beam, except as otherwise covered by this health benefit plan
- Indirect resin-based composite crowns
- Temporary or provisional crowns
- Removal of odontogenic and nonodontogenic cysts
- Cytology samples
- Dental implants when not CLINICALLY NECESSARY
- Dental procedures not directly associated with dental disease
- Dental procedures not performed in a dental setting
- Interim dentures
- Removable unilateral partial denture, including clasps and teeth
- Application of desensitizing materials
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard

tissue
- DENTAL SERVICES provided in a HOSPITAL
- Incision and drainage of abscess-extraoral soft tissue
- Maxillofacial prosthesis
- Occlusal guards for any purpose other than control of habitual grinding
- OFFICE VISITS for purposes of observation or presentation of treatment plan
- Orthodontic services, except as otherwise covered by this health benefit plan
- Periodontal related services such as anatomical crown exposure, apically positioned flap, surgical revisions and unscheduled charges
- Temporary or provisional pontics
- Pulp cap, direct or indirect
- Radiographs not specifically stated as covered are considered noncovered, such as skull and bone survey
- Tooth re-implantation or transplantation from one site to another
- Removal of foreign bodies or non-vital bones
- Services related to the salivary gland.

Pediatric Vision Services

This benefit is only available for MEMBERS up to the end of the month they become age 19.

This 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 part of a routine eye exam and are subject to the benefits, limitations and exclusions of this health benefit plan. NOTE: This benefit may only be available IN-NETWORK; see "Pediatric Vision and Hardware Services" in "Summary of Benefits."

This health benefit plan provides benefits for either one pair of eyeglass lenses and frames or one pair of contact lenses once per BENEFIT PERIOD in place of eyeglasses and certain low vision aids such as magnifiers. Benefits are also provided for low vision care, including one comprehensive low vision examination every five years, and four follow-up visits in any five year period. See "OFFICE VISIT Services" in "Summary of Benefits."

Pediatric Vision Exclusions

- Fitting for contact lenses, glasses or other hardware
- Diagnostic services that are not a component of a routine vision examination
- Services and materials not meeting accepted standards of optometric practice
- Visual therapy
- Replacement of lost or stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Replacement insurance for contact lenses.

PRESCRIPTION DRUG Benefits

Your PRESCRIPTION DRUG benefits cover the following:
- PRESCRIPTION DRUGS, including self-administered injectable medications, and contraceptive drugs and devices
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for long-term use in the treatment of clinical obesity

- 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 (see "Summary of Benefits.")
- Spacers for metered dose inhalers and peak flow meters, insulin and diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices. Supplies are also available under your MEDICAL SUPPLIES benefit. Benefits may vary for MEDICAL SUPPLIES, depending on whether supplies are received at a MEDICAL SUPPLY PROVIDER or at a pharmacy. See "Summary of Benefits"
- Certain PRESCRIPTION DRUGS related to treatment of INFERTILITY. INFERTILITY drugs are limited to quantity LIFETIME MAXIMUMS per MEMBER. For medical policy on INFERTILITY, see our website at **www.bcbsnc.com** and search on "infertility". For information on PRESCRIPTION DRUGS that have quantity limits, see **www.bcbsnc.com/content/services/formulary/rxnotes.htm**.

  PRESCRIPTION DRUGS indicated to treat INFERTILITY will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA). Visit **www.bcbsnc.com** for the most up-to-date information, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

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

Situation	Value
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. If you fail to show your ID CARD or the IN-NETWORK pharmacy's records do not show you as eligible for coverage, you will have to pay the full cost of the PRESCRIPTION and file a claim. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you. If you are unable to return to the pharmacy within 14 days, mail claims time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. 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 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 submit your own claim. 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 "Who to Contact?" so that the claim can be processed at the IN-NETWORK level
How the type of PRESCRIPTION DRUG may determine the amount you pay	Your PRESCRIPTION DRUG benefit has an open FORMULARY or list of PRESCRIPTION DRUGS, divided into categories or tiers. BCBSNC determines the tier placement of PRESCRIPTION DRUGS in the FORMULARY, and this determines the amount you pay. Tier placement of PRESCRIPTION DRUGS in the FORMULARY may be determined by the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally recognized drug-databases (ex. Medispan).

	The lowest cost PRESCRIPTION DRUGS, such as GENERICS, are generally located on the lowest tiers – Tier 1 and Tier 2. Higher cost PRESCRIPTION DRUGS, such as BRAND-NAME PRESCRIPTION DRUGS are generally located on higher tiers – Tiers 3, and 4. All tiers of the FORMULARY may contain GENERIC and BRAND-NAME PRESCRIPTION DRUGS. SPECIALTY DRUGS, if applicable, are located on the highest tier(s) of your plan, even though they may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR PRESCRIPTION DRUGS. Visit our website at **www.bcbsnc.com** for additional information on the tier classification of PRESCRIPTION DRUGS. The PRESCRIPTION DRUGS listed in the FORMULARY or their tier placement may change from time to time due to a change in the cost of the drug and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally recognized drug-databases (e.g. Medispan). Your PRESCRIPTION DRUG deductible does not apply to the medical BENEFIT PERIOD deductible.
How your PRESCRIPTION is dispensed	In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two or more different drugs in a compound to be dispensed. In these cases if you have copayments for PRESCRIPTION DRUGS, you will be responsible for one copayment, that of the highest tier drug in the compound, based on each 30-day supply. Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. For these drugs, you will pay either two or three copayments depending on the quantity you receive. Please see "Summary of Benefits." Certain combinations of compound drugs may require PRIOR REVIEW and CERTIFICATION. If you need to receive an extended supply (greater than a 30-day supply and up to a 90-day supply), visit our website at **www.bcbsnc.com** for a listing of retail pharmacies or mail-order service that can dispense an extended supply of your PRESCRIPTION. 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 if quantity limits apply, except during a government-declared state of emergency or disaster in the county in which you reside. During these circumstances, you must request a refill within 29 days after the date of the emergency or disaster (not the date of the declaration). A refill of a PRESCRIPTION with quantity limitations may take into account the proportionate dosage use prior to the disaster.
Use of Lower-Cost PRESCRIPTION DRUGS	When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may

	be higher. **Please note**: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If your PROVIDER requires you to take, or you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT. You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See **www.ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm** for a current list of these drugs; or 2) your PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply. 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 or services will not be covered. 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 SPECIALTY DRUGS (which include specialty GENERIC or BRAND–NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. These drugs are limited to a 30-day supply.This health benefit plan may not cover SPECIALTY DRUGS, see "Summary of Benefits." For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit our website at **www.bcbsnc.com**.
RESTRICTED-ACCESS DRUGS and Devices	Coverage will be provided for a RESTRICTED-ACCESS DRUG or device to a MEMBER without requiring PRIOR REVIEW or CERTIFICATION or use of a nonrestricted formulary drug if a MEMBER'S physician certifies in writing that the MEMBER has previously used an alternative nonrestricted-access drug or device and the alternative 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 prescribing physician, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition again.
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	Certain PRESCRIPTION DRUGS are subject to benefit limitations, which may include: the amount dispensed per PRESCRIPTION, per day or per defined time period; per lifetime; per month's supply; or the amount dispensed per single copayment, if applicable. Note: excess quantities are not covered.
Where to find more information	You may visit our website at **www.bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?" for the following: • List of IN-NETWORK pharmacies (including the Specialty Network); note this list may change from time to time • 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. You may also visit **www.bcbsnc.com/umdrug** for more information.

PRESCRIPTION DRUG Benefits Exclusions

Any PRESCRIPTION DRUG that is:

- Not specifically covered in this health benefit plan
- In excess of the stated quantity limits
- 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 unless specifically listed as a covered drug in the FORMULARY and a written PRESCRIPTION is provided
- Therapeutically equivalent to an over-the-counter drug
- Compounded and does not contain at least one ingredient is defined as a PRESCRIPTION DRUG (See "Glossary"). Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage
- 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.

Private Duty Nursing

This health benefit plan provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by a DOCTOR for a MEMBER who may be receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY. See "Care Management." Private duty nursing requires PRIOR REVIEW and CERTIFICATION 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 APPLIANCE 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. 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 or obstructive sleep apnea
- 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 preoperative and postoperative care and care of complications, are covered. Surgical benefits include diagnostic SURGERY such as biopsies 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 reimbursement policies, which are on our website at **www.bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to 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, this 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.

See PROVIDER'S Office, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."

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 applicable deductibles, copayment or coinsurance and limitations as applied to other medical and surgical benefits provided under this health benefit plan.

Temporomandibular Joint (TMJ) Services

This 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 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

This health benefit plan provides coverage for the following therapy services for illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

REHABILITATIVE and HABILITATIVE THERAPIES

The following therapies are covered:

- Occupational therapy and/or physical therapy (including chiropractic services and osteopathic

manipulation) up to a one-hour session per day
- 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 including chiropractic services, 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). REHABILITATIVE and HABILITATIVE THERAPIES received while an inpatient is not included in the BENEFIT PERIOD MAXIMUM. Benefits may vary depending on where services are received. See "Summary of Benefits" for additional information and any visit maximums.

OTHER THERAPIES

This health benefit plan covers:
- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy
- Chemotherapy, including intravenous chemotherapy. Chemotherapy benefits are based on where services are received. 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
- Group classes for pulmonary rehabilitation.

Transplants

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body. This 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 and charges related to a search for a donor 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 "Who to 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.
- 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.

WHAT IS NOT COVERED?

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?" This 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
- Services performed in 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 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, this 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 failure to keep a scheduled visit, completion of claim forms, obtaining medical records, late payments, and telephone charges.

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.

Alternative 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.

B

Collection and storage of **blood** and stem cells taken from the umbilical cord and placenta for future use in fighting a disease.

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

WHAT IS NOT COVERED? *(cont.)*

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 the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne and acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, electrolysis, and SURGERY for psychological or emotional reasons, except as specifically covered by this health benefit plan.

Services received either before or after the **coverage period** of this 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 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 described in "Dental Treatment Covered Under Your Medical Benefit"

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by this 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
- Drugs associated with assisted reproductive technology
- EXPERIMENTAL drugs or any drug not approved by the U.S Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS used in covered phases I, 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.

WHAT IS NOT COVERED? *(cont.)*

E

Services primarily for **EDUCATIONAL** TREATMENT 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 this 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 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
- Standing frames
- 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 this 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 for MEMBERS over the age of 22.

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.

Inpatient confinements that are primarily intended as a change of environment.

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 this health benefit plan.

M

Services or supplies deemed not **MEDICALLY NECESSARY.**

WHAT IS NOT COVERED? *(cont.)*

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 this health benefit plan.

P

Body **piercing**

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

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 and mental health 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 this 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.

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
- Massage therapy.

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except when approved in advance for transplants.

WHAT IS NOT COVERED? *(cont.)*

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.
- Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES" or "Pediatric Vision"
- Orthoptics, vision training, and low vision aids, except as specifically covered in "Pediatric Vision"
- Routine eye exams for adults.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, including medical foods with a PRESCRIPTION, except for PRESCRIPTION prenatal vitamins or PRESCRIPTION vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals. For the most up-to-date PREVENTIVE CARE services that are covered under federal law, see our website at **www.bcbsnc.com/preventive**.

W

Wigs, hair pieces and hair implants for any reason.

WHEN COVERAGE BEGINS AND ENDS

MEMBERS are eligible to receive benefits under this health benefit plan as long as BCBSNC has received confirmation from the Federal Government they meet the eligibility requirements established by the MARKETPLACE to be eligible for this health benefit plan. Provided below, as a convenience, is a list of eligibility requirements. This is not meant to be an exhaustive or binding list and may be subject to change by the Federal Government. For a full descriptive list of eligibility requirements see **www.healthcare.gov**.

- They are residents of North Carolina.
- They are residents of the Blue Value SERVICE AREA.
- They are not covered by Medicare as of the EFFECTIVE DATE of this health benefit plan.
- They are under the age of 21 as of the EFFECTIVE DATE, if they are enrolled in a child only plan.
- When applicable, they are eligible to receive a catastrophic plan.
- When applicable, they are eligible to receive cost sharing reductions
- When applicable, they are eligible to receive relevant special privileges as an American Indian or Alaska Native.

Please note, BCBSNC does not have any responsibility confirming or denying eligibility. Eligibility determinations are made solely by the MARKETPLACE.

Following receipt and approval of your application, coverage for you and your DEPENDENTS begins on the EFFECTIVE DATE of this health benefit plan. If you add one of the DEPENDENTS listed below after initial enrollment, and you do not select an EFFECTIVE DATE on the application, coverage for the DEPENDENTS will begin on the day their first premium is due, following receipt and approval of the Enrollment and Change application.

If BCBSNC accepts your DEPENDENT, the DEPENDENT will be an enrolled MEMBER. 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 an existing marriage that is legally recognized under any state law
- Your domestic partner, so long as you and your domestic partner meet the eligibility requirements determined by the Marketplace
- Your or your spouse's or your domestic partner's DEPENDENT CHILDREN, through the end of the BENEFIT PERIOD of their 26th birthday, including newborn children from date of birth, stepchildren, adoptive children from the date of placement for adoption and FOSTER CHILDREN from the date of placement in the foster home
- A DEPENDENT CHILD, who is or continues to be either mentally retarded or physically handicapped and incapable of self-support, may continue to be covered under this health benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the end of eligibility for DEPENDENT CHILDREN. The handicap must be medically certified by the child's doctor and may be verified annually by BCBSNC.

Only enrolled MEMBERS can receive the benefits described in this benefit booklet. The right to receive benefits is not transferable.

Enrolling in this Health Benefit Plan

Your eligibility, enrollment and effective date determinations for this health benefit plan will be handled through the MARKETPLACE. BCBSNC will be coordinating its enrollment activities with the MARKETPLACE so that you and your DEPENDENTS, if applicable, are enrolled within the timelines and processes established by the MARKETPLACE.

Annual Enrollment Period

The Annual Enrollment Period ("AEP") is November 1, 2015 to January 31, 2016. During these dates you

may apply for coverage or change your existing coverage.

Special Enrollment Periods

Special enrollment periods consist of a 60-day period following specified triggering events, unless noted below, during which you and/or your DEPENDENTS may enroll in this health benefit plan or change from one health benefit plan to another – outside of AEP. The EFFECTIVE DATE of coverage will depend on the triggering event.

Provided below, as a convenience, is a list of triggering events, the enrollment period and the EFFECTIVE DATE. This is not meant to be an exhaustive or binding list and may be subject to change by the Federal Government. For a full descriptive list of triggering events and their EFFECTIVE DATES see **www.healthcare.gov**.

Triggering Event	**Enrollment Period**	**EFFECTIVE DATE of Coverage**
You or your DEPENDENTS lose MINIMUM ESSENTIAL COVERAGE (MEC) (such as loss of coverage due to: death, divorce, Medicare eligibility, age (in the case of a child), termination of employment, employee enrolled in employer-sponsored plan is newly eligible for APTC based on change or discontinuance of employer-sponsored plan when able to terminate existing coverage, or reduction of hours)	60 Days prior to or after losing MEC	If plan selection is made on or before the loss of MEC – first day of the month following loss of coverage. If plan selection is made after the loss of coverage: 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS lose pregnancy related coverage or medically needy coverage as described in the Social Security Act (such as Medicaid)	60 Days prior to or after losing coverage	If plan selection is made on or before the loss of MEC – first day of the month following loss of coverage. If plan selection is made after the loss of coverage: 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS choose not to enroll or re-enroll in your non-calendar year group or individual health insurance coverage when the	60 Days prior to or after losing coverage	If plan selection is made on or before the loss of MEC – first day of the month following loss of coverage. If

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

plan renews		plan selection is made after the loss of coverage: 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS gain access to health benefit plan as a result of a permanent move	60 Days	1. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You gain a DEPENDENT or become a DEPENDENT through birth, adoption, placement for adoption, or placement as a FOSTER CHILD	60 Days	1. Date of birth, adoption, placement of adoption, or the date of the placement of a FOSTER CHILD in your home or date of court order (default), 2. First day of the month following birth, adoption, placement for adoption or placement in foster care, or 3. If apply between the 1st – 15th of the month = First day of the Following Month. If apply between the 16th – Last day of the month = First day of the Second Following Month
You gain a DEPENDENT or become a DEPENDENT through marriage	60 Days	First day of the month following enrollment
You gain a DEPENDENT or become a DEPENDENT via a court order	60 Days	1. EFFECTIVE DATE of court order (default) or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS gain US Citizen status	60 Days	If apply between the 1st – 15th of the month = First day of the following month.

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

		If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS are determined newly eligible or ineligible for advance payments of the premium tax credit (APTC) or have a change in eligibility for cost-sharing reductions, including being newly eligible for APTC due to an increase in income in a non-Medicaid expansion state	60 Days	If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS have demonstrated to the MARKETPLACE that you qualify as an American Indian or Alaska Native	60 Days	If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You or your DEPENDENTS demonstrate that the health benefit plan you were previously enrolled in substantially violated material provisions of the contract.	Up to 60 Days	As required by the MARKETPLACE
You or your DEPENDENTS have demonstrated to the MARKETPLACE that you meet other exceptional circumstances	Up to 60 Days	As required by the MARKETPLACE
You or your DEPENDENTS' enrollment or non-enrollment in another health benefit plan was made as a result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the MARKETPLACE or a non-Exchange entity providing enrollment assistance	Up to 60 Days	As required by the MARKETPLACE

This health benefit plan does not have any WAITING PERIODS for pre-existing conditions (a condition, disease, illness, or injury for which medical advice, diagnosis, care, or treatment was received or recommended within the 12-month period prior to your EFFECTIVE DATE) , unless otherwise specified in "Covered Services."

Reporting Changes

Have you moved, added or changed other health coverage, changed your name or phone number? You are required to report any changes that may impact your continued enrollment in this health benefit plan to the MARKETPLACE. The MARKETPLACE is responsible for determining your eligibility and for processing your enrollment in the MARKETPLACE. Visit **www.healthcare.gov** for more information. In addition to notifying the MARKETPLACE, you will receive better service if BCBSNC is also kept informed of these changes. Please visit our website at **www.bcbsnc.com** to update your information or call BCBSNC Customer Service at the number listed in "Who to Contact?" Please note that if you move outside of the Blue Value SERVICE AREA, it may impact your

eligibility for this product.

Renewing or Changing Your Coverage

If you continue to pay your premiums and meet the eligibility requirements, your coverage will continue, except as stated in the section "Termination of MEMBER Coverage." BCBSNC may modify your coverage as permitted by state or federal law.

You may only make changes to this health benefit plan during the annual enrollment period or during a special enrollment period.

Multiple Coverage

If you are enrolled in another insurance plan that offers medical coverage for any of the benefits under this health benefit plan, BCBSNC may reduce benefits under this health benefit plan to avoid paying benefits between the two plans that are greater than the cost of the health care service. If you are enrolled in a dental insurance plan that includes pediatric dental coverage, then this health benefit plan will be considered your primary plan and your dental insurance plan will be considered your secondary plan. If you or your DEPENDENTS become eligible for Medicare, you should apply for and enroll in Medicare Part A and Part B, and use PROVIDERS who accept Medicare in order to ensure that you receive full benefit coverage. BCBSNC will assume you have enrolled in Medicare and use PROVIDERS who accept Medicare once eligible for benefits thereunder. If you or your DEPENDENTS are covered under this health benefit plan and are eligible for Medicare, BCBSNC may take into account the benefits that you or your dependent are eligible for under Medicare, regardless of whether you have actually enrolled for such coverage. In other words, even if you have not enrolled in Medicare, BCBSNC may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this health benefit plan and in accordance with the Medicare Secondary Payer rules. As a result, your out-of-pocket costs may be higher if you do not enroll in Medicare.

Termination of MEMBER Coverage

A MEMBER'S termination shall be effective at 11:59 p.m. on the date that eligibility ends. A MEMBER may request termination from this health benefit plan at any time as long as the appropriate notice is given. You may contact the MARKETPLACE and request termination. Visit **www.healthcare.gov** for more information about termination events and notice requirements.

The MARKETPLACE may initiate termination of a MEMBER'S coverage in this health benefit plan and must allow BCBSNC to terminate such coverage for the reasons stated below. A MEMBER'S termination shall be effective the date of the event unless otherwise noted.

- The MEMBER is no longer eligible for coverage in this health benefit plan through the MARKETPLACE (termination is effective the last day of the month following the month you provide notice to the MARKETPLACE; however, you can request an earlier date. Example: You provide notice on March 15th, your termination date is April 30th);
- The MEMBER changes from one health benefit plan to another during the annual or special enrollment period (termination is effective the day before the start of the new coverage);
- This health benefit plan ends or is no longer allowed to be offered as a health insurance plan in the MARKETPLACE. If this health benefit plan is no longer allowed to be offered in the MARKETPLACE, BCBSNC may not terminate coverage until the MARKETPLACE has notified you and any enrolled DEPENDENTS, and you have had a chance to enroll in another health insurance plan;
- The MEMBER'S coverage is rescinded due to fraud or intentional misrepresentation of a material fact. However, if such termination is made retroactively, including back 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.

- The SUBSCRIBER fails to pay premiums on time. See "Premium Payments."

Certificate of CREDITABLE COVERAGE

BCBSNC will supply a Certificate of CREDITABLE COVERAGE when your or your DEPENDENT'S coverage under the health benefit plan ends. Keep the Certificate of CREDITABLE COVERAGE in a safe place. 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 1-888-206-4697 (toll-free) or visit our website at **www.bcbsnc.com**.

UTILIZATION MANAGEMENT

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 this 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 this 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 this 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.

UTILIZATION MANAGEMENT *(cont.)*

General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit our website at **BlueConnectNC.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a detailed list of these services.

If you fail to follow the procedures for filing a request, BCBSNC will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request.

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 to you and your PROVIDER within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required and 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.

Urgent PRIOR REVIEW

You have a right to an urgent 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. Your PROVIDER will be notified of the decision, and if the decision results in an ADVERSE BENEFIT DETERMINATION, written notification will be provided to you and your PROVIDER. If BCBSNC needs more information to process your urgent 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 after receipt of requested information or the end of the time period given to the PROVIDER to submit necessary clinical information.

An urgent review may be requested by calling BCBSNC Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

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

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting HOSPITAL or other facility within 3 business days after receipt of all necessary clinical information, but no later than 15 days after we receive 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 within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request.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.

Urgent Concurrent Review

If a request for an extension of treatment is urgent, and the request is received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated to the requesting HOSPITAL or other facility as soon as possible, but no later than 24 hours after we receive the request.

If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated as soon as possible, but no later than 72 hours after we receive the request. If BCBSNC needs more information to process your urgent review, BCBSNC will notify the requesting HOSPITAL or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. BCBSNC will make a decision within 48 hours of the earlier of receipt of the requested information, or the end of the time period given to the requesting HOSPITAL or other facility to provide the information.

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 and your PROVIDER 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 5 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 this 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 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.

UTILIZATION MANAGEMENT *(cont.)*

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 change health benefit plans or when your PROVIDER is no longer in the Blue Value 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
- 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; and
- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care.

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 "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

BCBSNC delegates UM for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Claims determinations 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?

In addition to the UM program, BCBSNC offers an appeals process for our MEMBERS. If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you have the right to request that BCBSNC review the decision or GRIEVANCE 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 or GRIEVANCE will determine the steps that you will need to follow in the appeals process. For appeals (including GRIEVANCES) relating to an ADVERSE BENEFIT DETERMINATION, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date indicated on your Explanation of Benefits.

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 website at **www.bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

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

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

MEMBERS may also receive assistance with ADVERSE BENEFIT DETERMINATIONS and GRIEVANCES from Health Insurance Smart NC. To reach this Program, contact:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free: 1-855-408-1212

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 10 business days.

Internal Appeals

If you are dissatisfied with an ADVERSE BENEFIT DETERMINATION or if you have a GRIEVANCE, you have the right to appeal (first level appeal). Within three business days after BCBSNC receives your appeal, BCBSNC will send you an acknowledgement letter which will include the name, address and telephone number of the appeals coordinator and instructions on how to submit written materials.

- During the internal appeals process you may:
  - request and receive from us all information that applies to your appeal
  - provide and/or present written evidence and testimony
  - 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 the final ADVERSE BENEFIT DETERMINATION
  - 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).

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. BCBSNC will consult with a North Carolina professional who has appropriate training and experience in the appropriate field of medicine. For all ADVERSE BENEFIT DETERMINATIONS and GRIEVANCES, BCBSNC will send you notification of the decisions in clear written terms within a reasonable time but no later than 30 days from the date BCBSNC received the appeal.

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. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a standard appeal apply to an expedited review. 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.

WHAT IF YOU DISAGREE WITH OUR DECISION? *(cont.)*

Second Level Review (Limited GRIEVANCES Only)

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

- Name, address and telephone number of the second level review coordinator
- Availability of Health Insurance Smart NC including address and telephone number
- A statement of your rights, including the right to:
  - request and receive from us all information that applies to your GRIEVANCE
  - participate in the second level review meeting
  - present your case to the review panel
  - submit supporting material before and during 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.

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 review request. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your GRIEVANCE even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting. This second level review is the last review available for GRIEVANCES.

External Review (Available only for NONCERTIFICATIONS)

Federal and state law provide 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.

However, 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 be considered to have exhausted the internal appeals process if you have:

- completed BCBSNC's appeals process and received a written determination on the appeal from BCBSNC, or
- filed an appeal and except to the extent that you have requested or agreed to a delay, have not received BCBSNC's written decision on the appeal within 60 days of the date you can show that you submitted the request, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeals process.

WHAT IF YOU DISAGREE WITH OUR DECISION? *(cont.)*

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. 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 final ADVERSE BENEFIT DETERMINATION from BCBSNC.

Expedited External Review

An expedited external review may be available if the time required to complete either an expedited internal 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 appeal; or
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION (also known as a final internal ADVERSE BENEFIT DETERMINATION).

In addition, prior to your discharge from an INPATIENT facility, you may also request an expedited external review after receiving a 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
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Tel (toll free): 1-855-408-1212
Fax: (919) 807-6865

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart/Smart_Contacts.aspx

(Web): **www.ncdoi.com/Smart** for external review information and request form
The Health Insurance Smart NC Program provides consumer counseling on utilization review and appeals issues.

Within ten business days (or, for an expedited review, within two 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, 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. 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 and Blue Shield of North Carolina
Member Appeals
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 days after receiving the additional information.

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within three days) after 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 the same day) after 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.

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to Which MEMBERS Are Entitled

The only legally binding benefits are described in this benefit booklet. 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 under this health benefit plan cannot be transferred or assigned to any other entity, including PROVIDERS. BCBSNC may pay a PROVIDER directly. For example, BCBSNC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with BCBSNC, and not through this health benefit plan. Under this health benefit plan, BCBSNC has the sole right to determine if payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under this health benefit plan, including but not limited to benefits, payments or procedures.

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 Value 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.

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 website at **www.bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

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 coverage of services, care, treatment, or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. The MARKETPLACE makes all eligibility determinations. The MARKETPLACE has the authority to make changes to their eligibility requirements at any time.

North Carolina 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 Value 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 Value ALLOWED AMOUNT and the contracted amount.

OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you may 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 service area 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 the BlueCard® Program, which is included in Inter-Plan Programs. 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 that 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.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

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.

Misrepresentation

If a MEMBER'S actions result in an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact, BCBSNC, in its discretion, may: 1) after 30 days advance written notice, void your policy and/or rider retroactive to the original EFFECTIVE DATE, and any premium paid may be refunded after BCBSNC deducts the amount for any claims paid, or 2) terminate your policy and/or rider immediately.

In the first two years of coverage, if there are any other false or incomplete statements on your application, BCBSNC, in its discretion, may reform your policy and/or rider to a higher rate tier resulting in the appropriate higher premium.

BCBSNC Modifications

No one may waive or change the coverage other than an officer authorized by the Board of Trustees. However, if any provision of this health benefit plan is in conflict with the statutes of North Carolina, it should be considered to be automatically amended to conform to the minimum requirements of such statutes. This benefit booklet, together with any amendments and applications for coverage is the entire agreement between you and BCBSNC. Any changes must be in writing.

BCBSNC Notifications

Any notice sent to a MEMBER, custodial parent or legal guardian is considered received by the MEMBER, custodial parent or legal guardian when deposited in the United States mail, with postage prepaid addressed to the MEMBER, custodial parent, legal guardian or agent at the address as shown on BCBSNC's records.

BCBSNC Contract

This policy is a contract between you and BCBSNC, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, permitting BCBSNC to use the Blue Cross and Blue Shield service marks in the state of North Carolina. BCBSNC is not contracting as an agent of the Blue Cross and Blue Shield Association. You hereby

acknowledge and agree that you have not entered into this policy based upon representations by any person other than BCBSNC and that no person, entity or organization other than BCBSNC shall be held accountable or liable to you for any obligations to you created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNC other than those obligations created under other provisions of this agreement.

This policy is made, executed and delivered in the State of North Carolina, and it and the MEMBER coverage provided shall be governed under the laws of the State of North Carolina, except to the extent preempted by federal law. Any provision of this policy that conflicts with the laws of the State of North Carolina is amended to conform to the minimum requirements of such laws.

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.

Limitation of Actions

No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the appeals process described in "What if You Disagree With Our Decision?" No legal action may be taken later than three years from the date services are INCURRED. Any legal action will be governed by North Carolina law.

SPECIAL PROGRAMS

Programs Outside Your Regular Benefits

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

- Health and wellness programs
- Discounts or promotional offers 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
- Rewards or drawings for gifts based on activities related to online tools found on BCBSNC's website
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Rewards for participation in wellness/educational activities. Reward type may be based on program participation levels and membership duration.
- Charitable donations made on your behalf by BCBSNC.

BCBSNC may not provide some or all of these items directly, but may instead arrange these for your convenience. These discounts or promotional offers are outside this 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 this 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.

GLOSSARY

These definitions will help you understand this health benefit plan. Please note that some of these terms may not apply to this health benefit plan.

ADVERSE BENEFIT DETERMINATION
A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit, including one that results from the application of any utilization review, or 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.

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.

AMERICAN INDIAN/ALASKA NATIVE PROVIDER
A PROVIDER operating under a health program administered by Indian Health Service, a federally recognized Indian tribe, tribal organization, or urban Indian organization or through referral under contract health services. Designation as an American Indian/Alaska Native provider is solely determined by the Federal Government.

ANCILLARY PROVIDER
Independent Clinical Laboratories, Durable/Home Medical Equipment and Supply providers, or Specialty Pharmacies**.** Ancillary providers are considered IN-NETWORK if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria:

a) For independent clinical laboratories, services are received in the state where the specimen is drawn

b) For durable/home medical equipment and supply PROVIDERS, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the plan in the state where the retail store is located
c) For specialty pharmacies, services are received in the state where the ordering physician is located.

BENEFIT PERIOD
The 12-month period of time, as stated in the "Summary of Benefits," 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.

BIOLOGIC
A complex large molecule drug produced from protein or living organisms.

BIOSIMILAR
PRESCRIPTION DRUG products approved by the U.S. Food and Drug Administration (FDA) that are subsequent versions of previously approved BIOLOGIC drugs, also known as follow-on biologics. Biosimilar drugs are manufactured after the patent and exclusivity protection of the BIOLOGIC drug have expired.

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. A brand-name drug has a trade name and is protected by a patent and can only be produced and sold by the manufacturer owning the patent. 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, such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

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.

CLINICALLY NECESSARY (or CLINICAL NECESSITY)
Those COVERED SERVICES, materials or supplies that are:
a) Provided for the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, or disease; and not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes, except as specifically covered by your dental benefit plan,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a dental condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of dental care in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

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

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 MAXIMUM 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, 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.

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, until the end of the BENEFIT PERIOD of their 26th birthday, who is either: 1) the SUBSCRIBER'S biological child, stepchild, legally adopted child (or child placed with the SUBSCRIBER and/or spouse or domestic partner for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to SUBSCRIBER and/or spouse or domestic partner, or 3) a child for whom the SUBSCRIBER and/or spouse or domestic partner has been court-ordered to provide coverage. The spouse, domestic partner or children of a dependent child are not considered DEPENDENTS.

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 that 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.

EDUCATIONAL TREATMENT
Services provided to foster acquisition of skills and knowledge to assist development of an individual's cognitive independence and personal responsibility. These services include academic learning, socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments.

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.

ESSENTIAL HEALTH BENEFITS
The core set of services that federal law requires to be included in this health benefit plan, and includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE and HABILITATIVE SERVICES and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. No annual or lifetime dollar limits can apply to essential health benefits.

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 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 has the same mechanism of action in the body as the BRAND-NAME drug. The classification of a PRESCRIPTION DRUG as a generic is determined by BCBSNC based on commercially available data resources and other external classification sources, such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

GRIEVANCE
Grievances include dissatisfaction with our decisions, policies or actions related to the availability, delivery or quality of health care services, or with the contractual relationship between the MEMBER and BCBSNC.

HABILITATIVE SERVICES
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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 that 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 that provides MEMBER identification numbers, names of the MEMBERS, and key benefit information, 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 after 12 consecutive months of unsuccessful attempts to conceive a child.

IN-NETWORK
Designated as participating in the Blue Value 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 Value provider by BCBSNC or a PROVIDER participating in the BlueCard® Program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate 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 U.S. 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 benefit maximum of certain COVERED SERVICES, such as INFERTILITY services, INFERTILITY drugs and orthotic devices for POSITIONAL PLAGIOCEPHALY, 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.

MARKETPLACE
The Marketplace is a new online health insurance marketplace run by either the State or Federal Government which permits individuals to shop for and buy qualified health benefit plans.

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-V"). Those mental disorders coded in the DSM-V as substance-related disorders, SEXUAL DYSFUNCTIONS not due to organic disease, and disorders coded as "V" codes are not included in the definition of Mental Illness.

MINIMUM ESSENTIAL COVERAGE (MEC)

MEC is (1) coverage under a specified government sponsored program; (2) coverage under an eligible employer-sponsored plan; (3) coverage under a health plan offered in the individual market within a State; (4) coverage under a grandfathered health plan; and (5) other health benefits coverage that the Secretary of Health and Human Services recognizes as MEC.

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under this 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. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetists (CRNAs). 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 HOSPITAL, that 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 U.S. 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 Value 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 the out-of-network copayment or coinsurance amount, if applicable.

OUT-OF-NETWORK PROVIDER
A PROVIDER that has not been designated as a Blue Value 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 Clinic 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.

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 U.S 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 that detect disease early in patients who do not show any signs or symptoms of a disease. Preventive care services include immunizations, medications that delay or prevent a disease, and screening and counseling services. Screening services are specific procedures and tests that identify disease and/or risk factors before the beginning of any signs and symptoms.

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.

REHABILITATIVE THERAPY(IES)
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.

RESIDENTIAL TREATMENT FACILITY(IES)
A residential treatment is a facility that either: (1) offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their chemical dependency or addiction to drugs or alcohol, or (2) offers treatment for patients that require psychiatric services for the diagnosis and treatment of MENTAL ILLNESS. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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.

RESTRICTED-ACCESS DRUGS
Covered PRESCRIPTION DRUGS or devices for which reimbursement by BCBSNC is conditioned on: (1) BCBSNC's giving CERTIFICATION to prescribe the drug or device or (2) the PROVIDER prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

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.

SERVICE AREA
The geographic area that Blue Value has been approved to be sold in by the federal and/or state government. To view a list of the counties in your plan's service area, please visit our website at **BlueConnectNC.com**. You may also contact Customer Service at the number listed on your ID CARD to find out if a county is in the service area.

Your plan's service area includes the following counties .

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.

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. Specialty drugs may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR.

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

SUBSCRIBER
The MEMBER who was listed on the application as the primary applicant and who is eligible and enrolled for coverage under this health benefit plan.

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 preoperative and postoperative care
c) Other procedures as reasonable and approved by BCBSNC.

TIER 1 DRUGS
The PRESCRIPTION DRUG tier which consists of the lowest cost tier of PRESCRIPTION DRUGS; most are GENERIC.

TIER 2 DRUGS
The PRESCRIPTION DRUG tier which consists of medium-cost PRESCRIPTION DRUGS; most are GENERIC, and some BRAND-NAME PRESCRIPTION DRUGS.

TIER 3 DRUGS
The PRESCRIPTION DRUG tier which consists of high-cost PRESCRIPTION DRUGS; most are BRAND-NAME PRESCRIPTION DRUGS.

TIER 4 DRUGS
The PRESCRIPTION DRUG tier which consists of the higher-cost PRESCRIPTION DRUGS; most are BRAND-NAME PRESCRIPTION DRUGS, and some SPECIALTY DRUGS.

TIER 5 DRUGS
The PRESCRIPTION DRUG tier which consists of the highest-cost PRESCRIPTION DRUGS; most are SPECIALTY DRUGS.

TOTAL OUT-OF-POCKET LIMIT
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 consists of the out-of-pocket expense (which is the annual maximum amount of coinsurance and any copayments) plus the deductible.

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 a MEMBER must be enrolled in this health benefit plan before receiving benefits for specific services.

SUMMARY OF BENEFITS

Blue Value Summary of Benefits
BENEFIT PERIOD – 01/01/2016 through 12/31/2016

Benefit payments are based on where services are received, how services are billed, and whether the PROVIDER is IN- or OUT-OF-NETWORK. IN-NETWORK PROVIDERS participate in the Blue Value network.

If you go to an OUT-OF-NETWORK PROVIDER, the following notice applies:

NOTICE: Your actual expenses for COVERED SERVICES may exceed the stated coinsurance percentage or copayment 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 copayment or coinsurance amounts.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Individual, per BENEFIT PERIOD	$700	$1,400
Family, per BENEFIT PERIOD	$1,400	$2,800
If this health benefit plan has copayments, these copayments do not apply to the BENEFIT PERIOD deductible.		
TOTAL OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$2,000	$4,000
Family, per BENEFIT PERIOD	$4,000	$8,000
Charges over ALLOWED AMOUNTS, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums and charges for noncovered services do not apply to the TOTAL OUT-OF-POCKET LIMIT.		
LIFETIME MAXIMUM	Unlimited	
Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY, INFERTILITY services 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.		
CERTIFICATION Requirements		
Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by BCBSNC in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military PROVIDERS. Otherwise, if you go to an OUT-OF-NETWORK PROVIDER in		

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
North Carolina or to any other PROVIDER outside of North Carolina, you are responsible for ensuring that you or 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 "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.** BCBSNC delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. To request PRIOR REVIEW, please see the numbers in "Who to Contact?"		
PREVENTIVE CARE		
For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received. This benefit is only available for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to BCBSNC. Also see "PREVENTIVE CARE" in "COVERED SERVICES."		
Federally-mandated PREVENTIVE CARE Services	No Charge	**Benefits not available**
Available in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center. For the most up-do-date list of PREVENTIVE CARE services that are covered under federal law, including PRESCRIPTION contraceptives and certain preventive over-the-counter medications, general preventive services and screenings, immunizations, well-baby/well-child care, and women's PREVENTIVE CARE, see our website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number listed in "Who to Contact?" Nutritional counseling visits are covered IN-NETWORK regardless of diagnosis.		
State-mandated PREVENTIVE CARE Services	No Charge	30% after deductible
The following services are state-mandated and required to be offered both IN- and OUT-OF-NETWORK: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
PROVIDER'S Office See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services.		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	\$5 copayment	60% after deductible
SPECIALIST	\$10 copayment	60% after deductible
CT Scans, MRIs, MRAs and PET Scans	30% after deductible	60% after deductible
Includes office SURGERY, second surgical opinion, consultation, x-rays, lab tests, and family planning.		
HABILITATIVE and REHABILITATIVE THERAPIES	\$10 copayment	60% after deductible

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
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		
INFERTILITY Services		
PRIMARY CARE PROVIDER	$5 copayment	60% after deductible
SPECIALIST	$10 copayment	60% after deductible
Combined IN- and OUT-OF-NETWORK LIFETIME MAXIMUM of three ovulation induction cycles, with or without insemination, per MEMBER for INFERTILITY services, provided in all places of service. See "INFERTILITY Services" and "PRESCRIPTION DRUG Benefits" for additional information. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.		
Pediatric DENTAL SERVICES		
Preventive and Diagnostic Services	No Charge	30% after deductible
Basic and Major Services	30% after deductible	60% after deductible
Orthodontic Services (if CLINICALLY NECESSARY)	30% after deductible	60% after deductible
The benefits listed above are only available for MEMBERS up to the end of the month they become age 19. See "Pediatric Dental" in "COVERED SERVICES" for a description of the available benefits. NOTE: there is a 12-month WAITING PERIOD on orthodontic services.		
Pediatric Vision Services		
Routine Eye Exams	$5 copayment	60% after deductible
Professional Services	$10 copayment	60% after deductible
Lenses and Frames	50% no deductible	
The benefits listed above are only available for MEMBERS up to the end of the month they become age 19. See "Pediatric Vision" in "COVERED SERVICES" for a description of the available benefits.		
Obesity Treatment/Weight Management		
PRIMARY CARE PROVIDER	$5 copayment	60% after deductible
SPECIALIST	$10 copayment	60% after deductible
Outpatient Physician Services	30% after deductible	60% after deductible
Outpatient HOSPITAL and HOSPITAL-based Services	30% after deductible	60% after deductible
Inpatient Physician Services	30% after deductible	60% after deductible

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
Inpatient HOSPITAL and HOSPITAL-based Services	30% after deductible	60% after deductible
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. See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
AMERICAN INDIAN/ALASKA NATIVE PROVIDERS		
If you are designated by the MARKETPLACE to be American Indian/Alaska Native, federal law requires that any COVERED SERVICES provided by AMERICAN INDIAN/ALASKA NATIVE PROVIDERS will be covered at no charge to you. If you receive a referral from an AMERICAN INDIAN/ALASKA NATIVE PROVIDER to see another PROVIDER, COVERED SERVICES from that PROVIDER will also be covered at no charge to you.		
URGENT CARE Centers, Emergency Room, and Ambulance		
URGENT CARE Centers	$10 copayment	$10 copayment
Emergency Room Visit	$100 copayment	$100 copayment
If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Ambulance Services	30% after deductible	30% after deductible
AMBULATORY SURGICAL CENTER		
AMBULATORY SURGICAL Services	30% after deductible	60% after deductible
Outpatient		
Physician Services	30% after deductible	60% after deductible
HOSPITAL and HOSPITAL-based Services	30% after deductible	60% after deductible
HOSPITAL-based or OUTPATIENT CLINIC	30% after deductible	60% after deductible
Therapy Services	30% after deductible	60% after deductible
Includes and HABILITATIVE and REHABILITATIVE THERAPIES, and OTHER THERAPIES including dialysis; see PROVIDER'S Office for visit maximums.		
Outpatient Diagnostic Services:		
Outpatient lab tests:		
physician and HOSPITAL-based services performed alone	No Charge	30% after deductible

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
physician services performed with another service	No Charge	60% after deductible
HOSPITAL and HOSPITAL-based services performed with another service	30% after deductible	60% after deductible
Other Outpatient Diagnostic Services:		
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	30% after deductible	60% after deductible
CT Scans, MRIs, MRAs and PET Scans	30% after deductible	60% after deductible
Outpatient diagnostic mammography (physician and HOSPITAL-based services)	No Charge	30% after deductible
See PREVENTIVE CARE for coverage of screening mammograms.		
Inpatient		
Physician Services	30% after deductible	60% after deductible
HOSPITAL and HOSPITAL-based Services	30% after deductible	60% after deductible
If you are in the 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.		
Maternity		
	30% after deductible	60% after deductible
Mental Health and Substance Abuse Services		
Office Services	$10 copayment	60% after deductible
Inpatient Services	30% after deductible	60% after deductible
Outpatient Services	30% after deductible	60% after deductible
SKILLED NURSING FACILITY		
	30% after deductible	60% after deductible
Combined IN-and OUT-OF-NETWORK maximum of 60 days per BENEFIT PERIOD. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES. Services applied to the deductible count towards the day maximum.		
Other Services		
	30% after deductible	60% after deductible
Includes blood, dental accident treatment, diabetes-related services, DURABLE MEDICAL EQUIPMENT, HOME HEALTH care, home infusion therapy services, HOSPICE services, MEDICAL SUPPLIES (includes select diabetic		

Benefits	IN-NETWORK	OUT-OF-NETWORK
supplies), orthotic devices, private duty nursing, and PROSTHETIC APPLIANCES. When covered, benefits for hearing aids are limited to one hearing aid per hearing-impaired ear per every 36 months for MEMBERS under the age of 22. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to a combined IN- and OUT-OF-NETWORK LIFETIME MAXIMUM of one device per MEMBER. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.		
PRESCRIPTION DRUGS		
TIER 1 DRUGS	$10 copayment	$10 copayment
TIER 2 DRUGS	$25 copayment	$25 copayment
TIER 3 DRUGS	$50 copayment	$50 copayment
TIER 4 DRUGS	$70 copayment	$70 copayment
TIER 5 DRUGS	25%	25%
Diabetic Supplies, Spacers and Peak Flow Meters	25%	25%
One copayment for up to a 30-day supply. 31-60-day supply is two copayments, and 61-90-day supply is three copayments. Limits apply to INFERTILITY drugs; see "PRESCRIPTION DRUG Benefits" for a detailed description. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.		
Preventive Over-the-Counter Medications and PRESCRIPTION contraceptive drugs and devices as listed at www.bcbsnc.com/preventive*	No Charge	No Charge**
*Please visit the website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES." **No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, the difference between the ALLOWED AMOUNT and the billed charge.		

Healthy Outcomes

BCBSNC offers health and wellness programs at no additional cost to MEMBERS. These confidential programs are designed to provide MEMBERS with targeted information and support services, which can help them improve their health as well as manage specific health care needs.

MEMBERS may receive comprehensive educational materials, tools and other resources. These programs also offer benefits for MEMBERS with certain conditions. The Healthy Outcomes program includes the following components:

- **Healthy Outcomes Case Management** – provides support to MEMBERS with various high risk health conditions to better manage the daily challenges of those conditions. MEMBERS are able to work one-on-one with a nurse coach.

- **Healthy Outcomes Condition Care** – provides disease management assistance to MEMBERS 18 years of age and older who are at risk and diagnosed with chronic health conditions through education, empowerment and support. MEMBERS enrolled in the program receive personalized support through targeted educational materials. Conditions supported include:

  - Chronic obstructive pulmonary disease (COPD)
  - Asthma
  - Diabetes
  - Congestive Heart Failure
  - Coronary Artery Disease

- **Healthy Outcomes Maternity** – provides support to female MEMBERS 18 years of age and older who are currently pregnant. This program offers initial and mid pregnancy assessments through a health coach, and additional nurse support via a 24/7 BabyLine®, which is available through 6 weeks post delivery.

- **Healthy Outcomes Wellness** – provides robust, integrated wellness offerings through a variety of media – on-line, and mail to help MEMBERS improve their health. This program includes a health assessment, virtual coaching programs, a personal health record, as well as a variety of tools, trackers, and newsletter articles.

- **Health Line Blue** – provides a toll-free, nurse-driven telephonic support program that empowers MEMBERS to better manage their health and make informed healthcare decisions. Highly trained registered nurses are available 24/7 to provide cost-effective solutions for MEMBERS coping with chronic and acute illnesses, episodic or injury-related events and other healthcare issues.

Full details on these programs, including a description of what's available and how to get started, are located on our website at ***www.bcbsnc.com***. To find out more about these programs or to determine which programs are available to you, log into **BlueConnectNC.com** or call 1-888-206-4697.

BlueValue℠

BCBSNC MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina (BCBSNC) member, you have the right to:

- Receive information about your coverage and your rights and responsibilities as a member
- Receive, upon request, facts about your plan, including a list of doctors and health care services covered
- Receive polite service and respect from BCBSNC
- Receive polite service and respect from the doctors who are part of the BCBSNC networks
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval
- Receive, upon request, a copy of BCBSNC's list of covered prescription drugs. You can also request updates about when a drug may become covered.
- Receive clear and correct facts to help you make your own health care choices
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage
- Participate with practitioners in making decisions about your health care
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC
- Make recommendations regarding BCBSNC's member rights and responsibilities policies
- Receive information about BCBSNC, its services, its practitioners and providers and members' rights and responsibilities
- Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service
- Read your BCBSNC benefit booklet and all other BCBSNC member materials
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24-hours notice.
- Play an active part in your health care
- Be polite to network doctors, their staff and BCBSNC staff
- Tell your place of work and BCBSNC if you have any other group coverage
- Tell your place of work about new children under your care or other family changes as soon as you can
- Protect your BCBSNC ID card from improper use
- Comply with the rules outlined in your member benefit guide.

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), (4) and (5) 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 $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
4. The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
5. The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.