Dear Group Administrator:

Welcome! Thank you for choosing Blue Cross and Blue Shield of North Carolina for your health care needs. We are pleased to provide you with quality health care. For your convenience, the following tools are available on our website at www.bcbsnc.com/employers/. Our website contains a Group Administrator Toolkit which will help you access the most up-to-date versions of the Group Administrator's Guide as well as a variety of Blue Cross and Blue Shield of North Carolina forms that you may need.

- Provider Directory - “Find a Doctor”
- Member Drug Formulary - “Find a Drug”
- Administrative Forms - "Forms"
- Enrollment/Change Form (in English and Spanish)
- Declination of Coverage Form (in English and Spanish)
- Prescription Drug Reimbursement Form
- Subscriber/Member Claim Form
- Group Administrator's Guide - Provides answers to commonly asked questions about eligibility, enrollment, billing, how to handle claims and inquiries.

We hope you find our website www.bcbsnc.com/employers/ useful and save it as a favorite link since features are routinely updated. If you do not have web access, please call Employer Services Line at the phone number below to request the contents of the Group Administrator toolkit. At Blue Cross and Blue Shield of North Carolina, we consider every interaction to be an opportunity to exceed expectations.

Again, thank you for choosing Blue Cross and Blue Shield of North Carolina.

Sincerely,

Blue Cross and Blue Shield of North Carolina

Employer Services Line (Enrollment/Billing) 1-877-237-6275
Customer Service (Claims/Benefits) 1-877-258-3334

Product/Group #/Benefit Package/Effective Date/Contract Print Date
BlueOptions/081732/320E/010118/092417
Benefit Booklet
For Employees of
ASO BO123 Copay BH
for
BlueOptions 123

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association
BENEFIT BOOKLET

This benefit booklet describes the ASO BO123 Copay BH EMPLOYEE health plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the PLAN document, the PLAN document will control.

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.
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IMPORTANT INFORMATION REGARDING THE PLAN:

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

Getting Started
This benefit booklet provides important information about your benefits and can help you understand how to maximize them. It’s important that you read the entire booklet. If you need help or more information, it tells you how to contact us in the "Who to Contact" section.

Notes on Words
As you read this booklet, keep in mind that any word you see in small caps is a defined term and appears in the "Glossary" at the end of the benefit booklet.

This booklet tells you about:
- your COVERED SERVICES and exclusions or services that are not covered
- how the PLAN works
- how we share expenses for COVERED SERVICES
- who is eligible to be covered under the PLAN and when this coverage starts and ends
- our UTILIZATION MANAGEMENT programs and the right to appeal the decision
- any Special Programs that may come with the PLAN.

PRIOR REVIEW and CERTIFICATION
Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a full denial of benefits. General categories of services are noted in “COVERED SERVICES.” Also see “PRIOR REVIEW/Pre-Service” in “UTILIZATION MANAGEMENT” for information about the review process, visit our website at bcbsnc.com, or call BCBSNC Customer Service to ask whether a specific service requires PRIOR REVIEW and CERTIFICATION. The list of services that require PRIOR REVIEW may change from time to time.

Exclusions and Limitations
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?”

More Information upon Request
You may receive, upon request, information about Blue Options 1-2-3, its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Medical and Reimbursement Policies
Certain services are covered pursuant to BCBSNC medical and reimbursement policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, a convenience item, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. The most up-to-date medical and reimbursement policies are available at bcbsnc.com, or call BCBSNC Customer Service at the number listed in “Who to Contact?”

Reduced or Waived Payments
From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services, therapies, or PRESCRIPTION DRUGS in connection with programs designed to reduce medical costs, or to encourage MEMBERS to seek appropriate, high quality, efficient care based on BCBSNC criteria.

Common Insurance Terms
To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below:

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<td><strong>Copayment</strong></td>
<td>The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the deductible; however, they are credited to the OUT-OF-POCKET LIMIT.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>The amount of money you must pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN begins to pay for COVERED SERVICES. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Your share of the costs of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET LIMIT</strong></td>
<td>The OUT-OF-POCKET limit is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% for COVERED SERVICES in a BENEFIT PERIOD. The OUT-OF-POCKET LIMIT includes your deductible, coinsurance, and copayments. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums, and charges for noncovered services.</td>
</tr>
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Please note: This health benefit plan was not specifically designed to be a high deductible health plan ("HDHP") under the Tax Code, and therefore is not intended to be paired with a health savings account ("HSA"). Check with a tax advisor to ensure qualification before you pair this health benefit plan with an HSA.

**For Help in Reading this Benefit Booklet**

BCBSNC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. BCBSNC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call 1-888-206-4697. For TTY and TDD, call 1-800-442-7028.

**Using Informational Graphics**

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements.

**Definitions**

This symbol calls attention to definitions of important terms throughout this benefit booklet. Additional terms are in the "Glossary" at the end of this benefit booklet. If you are unsure of the meaning of a term, please check "Glossary."

**Cross-Reference**

Throughout this benefit booklet, cross-references direct you to read other sections of the benefit booklet when necessary.

**Call for PRIOR REVIEW and CERTIFICATION Required**

This symbol calls attention to medical/surgical and mental health and substance abuse services which require PRIOR REVIEW and CERTIFICATION in order to avoid a full denial of benefits.

**Limitations and Exclusions**

Each subsection in "COVERED SERVICES" describes not only what is covered, but may also list some limitations and exclusions that specifically relate to a particular type of service. Limitations and exclusions that apply to all services are listed in "What Is Not Covered?"
## Toll-Free Phone Numbers, Website and Addresses

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<th><strong>BCBSNC Website:</strong> bcbsnc.com</th>
<th>Find IN-NETWORK PROVIDERS (includes pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about BCBSNC.</th>
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<tr>
<td><strong>Blue Connect Website:</strong> BlueConnectNC.com</td>
<td>Use our secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.</td>
</tr>
<tr>
<td><strong>BCBSNC Customer Service:</strong> 1-877-275-9787</td>
<td>For questions about your benefits, claims, new ID CARD requests or to voice a complaint.</td>
</tr>
<tr>
<td>TTY/TDD: 1-800-442-7028</td>
<td></td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUG Information:</strong> 1-877-275-9787</td>
<td>You may visit BCBSNC's 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 <a href="http://www.bcbsnc.com/umdrug">www.bcbsnc.com/umdrug</a> for more information.</td>
</tr>
<tr>
<td><strong>PRIOR REVIEW and CERTIFICATION:</strong> To request, MEMBERS call: 1-877-275-9787 PROVIDERS call: 1-800-672-7897</td>
<td>Some services need PRIOR REVIEW and CERTIFICATION from BCBSNC. Up-to-date information about which services may need PRIOR REVIEW can be found online at BlueConnectNC.com.</td>
</tr>
<tr>
<td><strong>Magellan Behavioral Health:</strong> 1-800-359-2422</td>
<td>BCBSNC delegates the administration of mental health and substance abuse benefits by contract to Magellan Behavioral Health, which is not associated with BCBSNC. See Delegated UTILIZATION MANAGEMENT for more information.</td>
</tr>
<tr>
<td><strong>Out of North Carolina Care:</strong> 1-800-810-BLUE(2583)</td>
<td>For help in obtaining care outside of North Carolina or the U.S., call this number or visit <a href="http://bcbs.com">bcbs.com</a>.</td>
</tr>
<tr>
<td><strong>HealthLine Blue℠:</strong> 1-877-477-2424</td>
<td>Talk to a nurse 24/7 to get timely information and help on a number of health-related issues. Nurses are on hand by phone in both English and Spanish.</td>
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## Toll-Free Phone Numbers, Website and Addresses (cont.)

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<td>Condition Care:</td>
<td>1-800-260-0091</td>
<td>Talk to a Condition Care Coach for information about programs and support for handling specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.</td>
</tr>
<tr>
<td>Condition Care Maternity:</td>
<td>1-855-301-2229</td>
<td>The maternity program will provide you with support for managing your pregnancy. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.</td>
</tr>
<tr>
<td>Healthy Outcomes</td>
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<tr>
<td>Customer Service:</td>
<td>1-877-719-9004</td>
<td>Talk with a representative to get help with any technical issues with the website, as well as questions about the Healthy Outcomes program. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.</td>
</tr>
<tr>
<td>Wellness Coaching:</td>
<td>1-888-292-5444</td>
<td>Wellness coaches provide behavioral support to help you manage lifestyle issues. Wellness support is available by phone, as well as by e-mail and live chat. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.</td>
</tr>
<tr>
<td>MDLIVE:</td>
<td>1-888-657-9982 or <a href="http://WWW.MDLIVE.COM/NCVIDEODOC">WWW.MDLIVE.COM/NCVIDEODOC</a></td>
<td>For access to a DOCTOR regarding nonemergency medical issues, call or visit the website to ask for a consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.</td>
</tr>
<tr>
<td>Medical Claims Filing:</td>
<td>BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035</td>
<td>Mail completed medical claims to this address.</td>
</tr>
<tr>
<td>PRESCRIPTION DRUG Claims Filing:</td>
<td>Prime Therapeutics Mail Route: BCBSNC PO Box 25136 Lehigh Valley, PA 18002-5136</td>
<td>Mail completed PRESCRIPTION DRUG claims to this address.</td>
</tr>
</tbody>
</table>
Value-Added Programs

Not all plans have these Value-Added programs. These programs are not covered benefits and are outside of the PLAN. To see if these programs are available, talk to your PLAN ADMINISTRATOR. BCBSNC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and BCBSNC may change or discontinue these programs at any time.

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Or call 1 (855) 511-BLUE (2583)
This section provides a summary of your Blue Options 1-2-3 benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply—please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- 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.
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options 1-2-3 IN-NETWORK PROVIDER. However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY, URGENT CARE, and Ambulance Services" in "COVERED SERVICES" for additional information on EMERGENCY care.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the PPO network before receiving care. Find a PROVIDER on BCBSNC’s website at bcbsnc.com or call BCBSNC Customer Service at the number listed on your ID CARD or in "Who to Contact?"
BENEFIT PERIOD - January 1, 2018 through December 31, 2018

Benefit payments are based on where services are received and how services are billed.

<table>
<thead>
<tr>
<th>Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following deductible, limits and maximums apply to the services listed below in the &quot;Summary of Benefits&quot; unless otherwise noted below. Services applied to the deductible also count toward any visit or day maximums.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Embedded Deductible</strong></td>
</tr>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

The PLAN has an embedded deductible which means MEMBERS must meet their individual deductible before benefits are payable under the PLAN. However, once the family deductible is met, all covered family members will be in benefit. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.

| **Embedded OUT-OF-POCKET LIMIT** | | |
|----------------------------------|------------------|
| Individual, per BENEFIT PERIOD | $6,600 | $13,200 |
| Family, per BENEFIT PERIOD | $13,200 | $26,400 |

Charges applied to your OUT-OF-NETWORK coinsurance are credited to your IN-NETWORK OUT-OF-POCKET LIMIT. However, charges applied to your IN-NETWORK coinsurance are not credited to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.

The PLAN has an embedded OUT-OF-POCKET LIMIT which means any MEMBER who meets their individual OUT-OF-POCKET LIMIT will have the benefit levels apply to them only and not the entire family. However, once the family OUT-OF-POCKET LIMIT is met, the benefit levels will apply to the entire family. Charges for IN-NETWORK services apply to your IN-NETWORK OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.

<table>
<thead>
<tr>
<th>LIFETIME MAXIMUMS per MEMBER</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceptions to the unlimited LIFETIME MAXIMUM are listed below. 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.</td>
<td></td>
</tr>
<tr>
<td>INFERTILITY Services</td>
<td>Three ovulation induction cycles, with or without insemination per MEMBER provided in all places of service</td>
</tr>
<tr>
<td>INFERTILITY PRESCRIPTION DRUGS</td>
<td>Limits apply, see &quot;PRESCRIPTION DRUG Benefits&quot; in &quot;COVERED SERVICES&quot;</td>
</tr>
<tr>
<td>Orthotic Devices for POSITIONAL PLAGIOCEPHALY</td>
<td>One device</td>
</tr>
<tr>
<td>Vein Treatment</td>
<td>Endovenous procedures—one procedure per limb</td>
</tr>
</tbody>
</table>
### Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums

The following deductible, limits and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted below. Services applied to the deductible also count toward any visit or day maximums.

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sclerotherapy vein treatment—three procedures per limb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Benefit Period Maximums per MEMBER

Any services in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.

- **Adaptive Behavior Treatment**: Limited to $40,000 up to age 19
- **Dialysis Treatment**: Three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY
- **Evaluation and Treatment of Obesity**: Four OFFICE VISITS
- **Hearing Aids**: When covered, one hearing aid per hearing-impaired ear every 36 months for MEMBERS under age 22
- **Rehabilitative and Habilitative Therapies** (applies to home, office and outpatient setting): 30 for physical/occupational therapy, 30 for speech therapy
- **Skilled Nursing Facility**: 60 days

---

8
## Summary of Benefits (Cont.)

### Level 1 Benefits

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screenings</strong></td>
<td>No Charge</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>This includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Preventive Care (Federally mandated)</strong></td>
<td>No Charge</td>
<td>Benefits not available</td>
</tr>
<tr>
<td>For a list of Preventive Care services that are covered under Federal law, see BCBSNC’s website at <a href="http://www.bcbsnc.com/preventive">www.bcbsnc.com/preventive</a> or call BCBSNC Customer Service at the number in &quot;Who to Contact?&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please note that the following services are also covered at No Charge IN-NETWORK: routine eye exams and nutritional counseling visits, regardless of diagnosis (benefits for nutritional counseling visits are also available OUT-OF-NETWORK at 30% after deductible).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Primary Care Office-based Services

<table>
<thead>
<tr>
<th></th>
<th>PCP $35 copayment</th>
<th>50% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine</td>
<td>$35 copayment</td>
<td>Benefits not available</td>
</tr>
</tbody>
</table>

Includes office visits, consultations, second opinions, x-rays, lab tests and surgery. If lab tests are sent to a hospital or hospital-based or outpatient clinic for processing, see Level 3 Benefits. For these services provided by a specialist, see Level 3 Benefits.
**LEVEL 2 BENEFITS**

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
</table>

### Inpatient Services

**HOSPITAL and HOSPITAL-based Services**
- **Inpatient Services**
  - **HOSPITAL and HOSPITAL-based Services**: $250 per admission copayment, then 20% after deductible. $500 per admission copayment, then 50% after deductible.
  - **Physician Services**: 20% after deductible. 50% after deductible.

Includes maternity delivery, prenatal, and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.

**Mental Health Services**
- **HOSPITAL and HOSPITAL-based Services**: $250 per admission copayment, then 20% after deductible. $500 per admission copayment, then 50% after deductible.
- **Physician Services**: 20% after deductible. 50% after deductible.

**RESIDENTIAL TREATMENT FACILITY Services**
- **HOSPITAL and HOSPITAL-based Services**: $250 per admission copayment, then 20% after deductible. $500 per admission copayment, then 50% after deductible.
- **Physician Services**: 20% after deductible. 50% after deductible.

**Substance Abuse Services**
- **HOSPITAL and HOSPITAL-based Services**: $250 per admission copayment, then 20% after deductible. $500 per admission copayment, then 50% after deductible.
- **Physician Services**: 20% after deductible. 50% after deductible.

### Other Services

**Ambulance Services**
- 20% after deductible. 20% after deductible.

Ambulance services related to inpatient care or an inpatient admission.

**Private Duty Nursing**
- 20% after deductible. 50% after deductible.

**SKILLED NURSING FACILITY**
- 20% after deductible. 50% after deductible.

**Home Health Care**
- 20% after deductible. 50% after deductible.

**HOSPICE Care**
- 20% after deductible. 50% after deductible.

Includes services provided in the home or inpatient setting.
### LEVEL 3 BENEFITS

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
</table>

#### SPECIALIST Office-based Services

<table>
<thead>
<tr>
<th>SPECIALIST OFFICE VISIT Services</th>
<th>40% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
</table>

Includes services such as consultations, second surgical opinions, SURGERY, x-rays and lab tests. Lab services billed by a SPECIALIST or IN-NETWORK independent lab are covered at no cost to you. However, independent pathology services, and lab tests sent to a HOSPITAL or HOSPITAL-based or OUTPATIENT CLINIC for processing, are covered at Level 3 Benefits.

**Colonoscopy** (treatment-related, outside of normal screening/wellness process) 40% after deductible 50% after deductible

**INFERTILITY Services**

40% after deductible 50% after deductible

**REHABILITATIVE and HABILITATIVE THERAPIES**

Includes chiropractic services, physical therapy, occupational therapy, and speech therapy.

40% after deductible 50% after deductible

**OTHER THERAPIES**

Includes chemotherapy, dialysis, cardiac rehabilitation, and pulmonary, radiation and respiratory therapy.

40% after deductible 50% after deductible

**Mental Health Office Services**

40% after deductible 50% after deductible

**Substance Abuse Office Services**

40% after deductible 50% after deductible

#### URGENT CARE and EMERGENCY SERVICES

<table>
<thead>
<tr>
<th>URGENT CARE Center</th>
<th>40% after deductible</th>
<th>40% after deductible</th>
</tr>
</thead>
</table>

**Emergency Room Visit**

40% after deductible 40% after deductible

If admitted to the HOSPITAL from the emergency room, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. See inpatient HOSPITAL services in Level 2 Benefits.

#### Outpatient Services

<table>
<thead>
<tr>
<th>Outpatient HOSPITAL Services</th>
<th>40% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
</table>

Includes physician services, HOSPITAL and HOSPITAL-based services, HOSPITAL-based or OUTPATIENT CLINIC services, AMBULATORY SURGICAL CENTERS, birthing centers, SURGERY, lab tests sent from a PCP’S or SPECIALIST’S office to a HOSPITAL or HOSPITAL-based or OUTPATIENT CLINIC for processing, outpatient diagnostic services such as lab tests, x-rays, ultrasounds, and other diagnostic tests such as EEGs, EKGs, and pulmonary function tests, REHABILITATIVE and HABILITATIVE THERAPIES and OTHER THERAPIES.

**Colonoscopy** (treatment-related, outside of normal screening/wellness process) 40% after deductible 50% after deductible

**Screening Mammography**

See PREVENTIVE CARE services under Level 1 Benefits

**Outpatient diagnostic mammography** (physician and HOSPITAL based services) 30% after deductible

**CT Scans, MRIs, MRAs and PET Scans** provided in any setting 40% after deductible 50% after deductible
<table>
<thead>
<tr>
<th>LEVEL 3 BENEFITS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Outpatient Services</td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Substance Abuse Outpatient Services</td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT, Home Infusion Therapy, MEDICAL SUPPLIES, Orthotic Devices, PROSTHETIC APPLIANCES</strong></td>
<td>40% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Ambulance</td>
<td>40% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>
**PRESCRIPTION DRUGS**

(The three levels of benefits do not apply to PRESCRIPTION DRUGS. Benefits are as follows.)

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If 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 [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm](http://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 would still apply.

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRESCRIPTION DRUG Deductible</strong></td>
<td>$100 per MEMBER, per BENEFIT PERIOD</td>
</tr>
<tr>
<td>TIER 1 DRUGS</td>
<td>$4 copayment</td>
</tr>
<tr>
<td>TIER 2 DRUGS</td>
<td>$35 copayment after PRESCRIPTION DRUG deductible</td>
</tr>
<tr>
<td>TIER 3 DRUGS</td>
<td>$50 copayment after PRESCRIPTION DRUG deductible</td>
</tr>
<tr>
<td>TIER 4 DRUGS</td>
<td>25% after PRESCRIPTION DRUG deductible</td>
</tr>
<tr>
<td>Diabetic Supplies, Spacers and Peak Flow Meters</td>
<td>25% after PRESCRIPTION DRUG deductible</td>
</tr>
</tbody>
</table>

One copayment for up to a 30-day supply. 31-60-day supply is two copayments, and 61-90-day supply is three copayments. For each 30-day supply of a TIER 4 DRUG, you will pay a minimum of $50 in coinsurance, but not more than $100. Any OUT-OF-NETWORK charges over the ALLOWED AMOUNT are not included in this maximum. Limits apply to INFERTILITY drugs, see "PRESCRIPTION DRUG Benefits" for a detailed description. Also see Enhanced 4 Tier C FORMULARY at [http://www.bcbsnc.com/enhanced4tierC](http://www.bcbsnc.com/enhanced4tierC).

**Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at [www.bcbsnc.com/preventive](http://www.bcbsnc.com/preventive)**

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Charge</td>
<td>No Charge**</td>
</tr>
</tbody>
</table>

* Please visit BCBSNC’s website at [www.bcbsnc.com/preventive](http://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.
CERTIFICATION Requirements

Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. BCBSNC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with BCBSNC. Please see https://www.bcbsnc.com/content/services/medical-policy/index.htm for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit https://www.bcbsnc.com/content/services/medical-policy/index.htm.
This section provides information about choosing services at the most cost-effective benefit level. It tells you about:

<table>
<thead>
<tr>
<th>Table of Contents:</th>
<th>Key Words:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most cost-effective benefit level</td>
<td>ALLOWED AMOUNTS vs. Billed</td>
</tr>
<tr>
<td>ALLOWED AMOUNTS vs. Billed Amount</td>
<td>PRIOR REVIEW</td>
</tr>
<tr>
<td>Referrals</td>
<td>PRIMARY CARE PROVIDER</td>
</tr>
<tr>
<td>After-hours care</td>
<td>SPECIALIST</td>
</tr>
<tr>
<td>Care outside of North Carolina</td>
<td></td>
</tr>
<tr>
<td>PRIOR REVIEW</td>
<td></td>
</tr>
<tr>
<td>Filing claims</td>
<td></td>
</tr>
<tr>
<td>OUT-OF-NETWORK Benefit Exceptions</td>
<td></td>
</tr>
<tr>
<td>Carry your IDENTIFICATION CARD</td>
<td></td>
</tr>
<tr>
<td>Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST</td>
<td></td>
</tr>
</tbody>
</table>

As a MEMBER of the Blue Options 1-2-3 plan, you will enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options 1-2-3 network. This PLAN also allows you to keep your out-of-pocket costs low by choosing services at the most cost-effective benefit level.

See the illustration below for a quick snapshot of the three benefit levels and some of the services in each category.

<table>
<thead>
<tr>
<th>Level 1:</th>
<th>Level 2:</th>
<th>Level 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE PROVIDER (PCP) and all PREVENTIVE CARE services</td>
<td>Inpatient acute care and related services</td>
<td>Outpatient services and SPECIALIST office-based services</td>
</tr>
<tr>
<td>Sample Services:</td>
<td>Sample Services:</td>
<td>Sample Services:</td>
</tr>
<tr>
<td>PREVENTIVE CARE:</td>
<td>Inpatient HOSPITAL Services</td>
<td>Outpatient HOSPITAL:</td>
</tr>
<tr>
<td>- Routine physical exams</td>
<td>- Home Health Care</td>
<td>- X-rays &amp; lab tests (includes lab tests processed for a PCP or SPECIALIST)</td>
</tr>
<tr>
<td>- Well-baby care</td>
<td>- HOSPICE Care</td>
<td>- Outpatient SURGERY</td>
</tr>
<tr>
<td>- Well-child care</td>
<td>SKILLED NURSING FACILITY Care</td>
<td>REHABILITATIVE and HABILITATIVE THERAPY</td>
</tr>
<tr>
<td>- Immunizations</td>
<td>Inpatient Mental Health/Substance Abuse</td>
<td>Emergency room</td>
</tr>
<tr>
<td>- Vaccinations</td>
<td>Ambulance</td>
<td>AMBULATORY SURGICAL CENTER</td>
</tr>
<tr>
<td>- Screening services:</td>
<td>Private Duty Nursing</td>
<td>SPECIALIST Office-based Services:</td>
</tr>
<tr>
<td>- Pap test</td>
<td></td>
<td>- SURGERY</td>
</tr>
<tr>
<td>- Mammography screening</td>
<td></td>
<td>- Lab &amp; radiology</td>
</tr>
<tr>
<td>- Colorectal screening</td>
<td></td>
<td>- Mental health services</td>
</tr>
<tr>
<td>- Well-woman care</td>
<td></td>
<td>- Substance abuse services</td>
</tr>
<tr>
<td>- Prostate exam</td>
<td></td>
<td>URGENT CARE centers</td>
</tr>
<tr>
<td>- Bone mass measurement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Before receiving medical care, it is important that you refer to the "Summary of Benefits" to determine which benefit will apply. With this PLAN, you have the opportunity to control your health care costs by exploring your treatment options and choosing the most cost-effective way to access services. For example, you may want to use your PCP for basic wellness and sick care in order to receive Level 1 benefits, the highest level of coverage available. Here is a look at a few examples that will help illustrate the difference in cost to you when exploring your treatment options and where you receive that treatment:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Level 1: Provided in PCP'S Office Benefit: $20 Copayment (no Deductible Required)</th>
<th>Level 3: Provided in SPECIALIST'S Office Benefit: 30% Coinsurance after Deductible</th>
</tr>
</thead>
</table>
HOW BLUE OPTIONS 1-2-3 WORKS (cont.)

| OFFICE VISIT with skin lesion removal | Your cost: $20 | Total Charge: $160.00  
Your cost*: $48.00 |
| OFFICE VISIT with chest x-ray | Your cost: $20 | Total Charge: $90.00  
Your cost*: $27.00 |
| OFFICE VISIT with sinus x-ray | Your cost: $20 | Total Charge: $100.00  
Your cost*: $30.00 |

*All Level 3 examples above only show your coinsurance amount. Your deductible must be met first.

NOTE: The copayment and coinsurance amounts shown above are for example only, and represent services provided by an IN-NETWORK PROVIDER. Please refer to the "Summary of Benefits" for information specific to your coverage.

Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS, please visit BCBSNC’s website at bchsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?" Here's a look at how it works:

<table>
<thead>
<tr>
<th>Type of PROVIDER</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
</table>
| **OFFICE VISIT with skin lesion removal** | IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with 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 provided, even if they participate in the BlueCard® program. See "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on BCBSNC’s website at bchsnc.com, or call BCBSNC Customer Service at the number listed in “Who to Contact?” | OUT-OF-NETWORK PROVIDERS are not designated as Blue Options 1-2-3 PROVIDERS by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."

| ALLOWED AMOUNT vs. Billed Amount | If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and noncovered expenses. (See Filing Claims below for additional information.) | You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable copayment, deductible, coinsurance, and non-covered expenses. |

| Referrals | BCBSNC does not require you to obtain any referrals. |
| 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. |
| Care Outside of North Carolina | Your ID CARD gives you access to participating PROVIDERS outside the state |
| | If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, |
**OUT-OF-NETWORK BENEFIT EXCEPTIONS**

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC’s access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at your IN-NETWORK 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.

<table>
<thead>
<tr>
<th><strong>IN-NETWORK</strong></th>
<th><strong>OUT-OF-NETWORK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>of North Carolina through the BlueCard® program, and benefits are provided at the IN-NETWORK benefit level.</td>
<td>you will receive the lower OUT-OF-NETWORK benefit. Also see &quot;OUT-OF-NETWORK Benefit Exceptions.&quot;</td>
</tr>
</tbody>
</table>

**PRIOR REVIEW**

All IN-NETWORK PROVIDERS in North Carolina and some outside North Carolina are responsible for requesting PRIOR REVIEW when necessary.

See "COVERED SERVICES” and “PRIOR REVIEW (Pre-Service)” in UTILIZATION MANAGEMENT” for additional information about those services which require PRIOR REVIEW and CERTIFICATION.

Out-OF-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by BCBSNC.

You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by BCBSNC.

Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. However, 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, or the IN-NETWORK pharmacy’s records do not show as eligible for coverage. 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 necessary. 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 the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.

You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.
For more information, see one of the following sections: "EMERGENCY, URGENT CARE and Ambulance Services" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC’s access to care standards, visit BCBSNC’s website at bcbnsnc.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 Options 1-2-3 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 BCBSNC’s website at BlueConnectNC.com or call BCBSNC Customer Service at the number listed in "Who to Contact?"

**The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST**
With this PLAN, you will receive the highest level of benefits when receiving PREVENTIVE CARE services, or when receiving non-preventive care office-based services from a PCP. If you receive office-based services (non-preventive care) from a SPECIALIST, these services are on Level 3, and you will pay deductible and coinsurance.

THE PLAN does not require that you designate a 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 BCBSNC's website at bcbnsnc.com or call BCBSNC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the BCBSNC 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?"
This section provides a more complete description of your benefits, along with some exceptions or services that are not covered by the PLAN. Keep in mind as you read this section Blue Options 1-2-3 covers only those services that are MEDICALLY NECESSARY. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. We have grouped these COVERED SERVICES listed below to make it easier for you to find what you are looking for.

### Table of Contents:
- Office Services
- PREVENTIVE CARE
- EMERGENCY Care, URGENT CARE, Ambulance Services
- HOSPITAL and Other Facility Care
- Alternatives to HOSPITAL Stays
- Family Planning
- Specific Therapies and Tests
- Other Services
- Surgical Benefits
- Mental Health/Substance Abuse Benefits
- PRESCRIPTION DRUG Benefits

### Key Words:
- OFFICE VISIT
- Outpatient Clinic
- PREVENTIVE CARE
- IN-NETWORK
- OUT-OF-NETWORK
- REHABILITATIVE/HABILITATIVE THERAPIES
- ADAPTIVE BEHAVIOR TREATMENT
- GENERIC and PRESCRIPTION DRUGS

### Office Services
The PLAN covers care you receive as part of an OFFICE VISIT, including:

- electronic visit
- evaluation and treatment of obesity
- house call
- telemedicine services which include evaluation, management and consultation services for nonemergency medical issues with a PROVIDER via an interactive audio/video telecommunications system. See MDLIVE in "Who to Contact?" to access a DOCTOR who can diagnose and recommend treatment. Telemedicine services from MDLIVE will be subject to your PCP copayment and/or coinsurance and any applicable deductible. You can also check with your PROVIDER to see if telemedicine services are available; your benefit will depend on the type of PROVIDER supplying these services.

If the PLAN has a copayment 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.

It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services. If you receive these services from your PCP, you will receive the higher Level 1 benefit, while most OFFICE VISITS to a SPECIALIST will be reimbursed at Level 3.

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. See Level 3 Benefits in "Summary of Benefits."

Some PROVIDERS may get ancillary services, such as laboratory services, medical equipment and supplies or SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed.

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.

### PREVENTIVE CARE
The PLAN covers PREVENTIVE CARE services that can help you stay safe and healthy.

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 note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal regulations as being eligible. Services, such as diagnostic lab tests, that may be delivered with a PREVENTIVE CARE service
are not considered PREVENTIVE CARE. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your IN-NETWORK benefit level for the location where services are received. In addition, 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, the PLAN may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.

Please visit BCBSNC's 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 any limitations that may apply. Certain over-the-counter medications may also be available. These over-the-counter medications are covered only as indicated and when a PROVIDER’S PRESCRIPTION is presented at a pharmacy.

Some services are only available IN-NETWORK as indicated below.

PREVENTIVE CARE COVERED SERVICES include:

**Routine Physical Examinations and Screenings**
Routine physical examinations and related diagnostic services and screenings are covered for MEMBERS as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF).

This benefit is only available IN-NETWORK.

**Well-Baby and Well-Child Care**
These services are covered for each MEMBER including periodic assessments as recommended by the Health Resources and Services Administration (HRSA).

This benefit is only available IN-NETWORK.

**Well-Woman Care**
These services are covered for each female MEMBER, including periodic assessments, screenings, counseling, or support services, as recommended by the Health Resources and Services Administration (HRSA).

**Contraceptive Methods**
Contraceptive methods and procedures requiring a PRESCRIPTION and approved by the U.S. Food and Drug Administration are covered for each female MEMBER with reproductive capacity. This includes intrauterine devices, diaphragms and caps, injectable or transdermal contraceptives, NuvaRing®, implanted hormonal contraceptives, certain emergency contraceptives and GENERIC oral contraceptives.

This benefit is only available IN-NETWORK.

**Immunizations**
Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered. NOTE: the shingles vaccine is covered in accordance with the Food and Drug Administration (FDA) guidelines.

This benefit is only available IN-NETWORK, except for meningococcal vaccine which is also available OUT-OF-NETWORK.

**Routine Eye Exams**
Benefits are only available IN-NETWORK. This benefit is considered non-mandated preventive care.

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

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

**Bone Mass Measurement Services**
The 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. Lab work done as a result of a colorectal screening exam 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. However, lab work for the removal of polyps during the screening exam is considered PREVENTIVE CARE.

**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 a 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. Additional PSA tests will be covered if recommended by a DOCTOR.

**Screening Mammograms**
The 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 Exclusions

- Immunizations required for occupational hazard or international travel
- Fitting for contact lenses, glasses or other hardware
- Male contraceptives
- Diagnostic services that are not a component of a routine vision examination
- Diagnostic services used for prevention or screening that are not recognized as recommended preventive care services (Grade A or B) by the United States Preventive Services Task Force, and filed with a preventive/wellness diagnosis, including, but not limited to:
  - Albumin (urine) testing
  - Chest x-rays
  - EKGs
  - Iron level testing
  - Testosterone level testing
  - Thyroid function testing
  - Urinalysis
  - Vitamin B or D serum testing

For information on how these services would be covered as diagnostic, see Diagnostic Services in "COVERED SERVICES."

EMERGENCY, URGENT CARE and Ambulance Services
The PLAN provides benefits for EMERGENCY SERVICES.

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

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

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

What to Do in an EMERGENCY

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Benefit</th>
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<tbody>
<tr>
<td>You go to an IN-NETWORK HOSPITAL emergency room.</td>
<td>Applicable ER copayment, deductible and/or coinsurance. PRIOR REVIEW and CERTIFICATION are not required.</td>
</tr>
<tr>
<td>You go to an OUT-OF-NETWORK HOSPITAL emergency room.</td>
<td>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.</td>
</tr>
<tr>
<td>You are held for observation.</td>
<td>Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.</td>
</tr>
<tr>
<td>You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES.</td>
<td>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) or services will be denied. You may need to transfer to an IN-NETWORK HOSPITAL once your condition is stabilized in order to continue receiving IN-NETWORK benefits.</td>
</tr>
<tr>
<td>You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged.</td>
<td>Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.</td>
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**URGENT CARE**

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

**Ambulance Services**

The 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. Benefits will vary; if the ambulance services are related to inpatient care or an inpatient admission see Level 2 Benefits; otherwise, Level 3 Benefits apply.

The PLAN covers services in an air ambulance only when: (i) ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land, and (ii) 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. Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

**Ambulance Service Exclusions**
- No benefits are provided primarily for the convenience of travel.
- Transportation to or from a DOCTOR’S office or dialysis center
HOSPITAL (Inpatient) and Other Facility Care

Benefits are provided for:

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

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY, URGENT CARE and Ambulance Services." If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT OF NETWORK inpatient admissions, services will be denied. Also, BCBSNC requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or an OUTPATIENT CLINIC

- Surgical services received in an AMBULATORY SURGICAL CENTER

- COVERED SERVICES received in a SKILLED NURSING FACILITY.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC or services will not 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.

Alternatives to HOSPITAL Stays (home health care, HOSPICE, private duty nursing)

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 needs part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care services like REHABILITATIVE and HABILITATIVE 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.

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.

Private Duty Nursing

The PLAN provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your 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.

Family Planning
Maternity Care
Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS and are covered as part of the global delivery fee. See the chart below for additional information. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for complications of pregnancy. Also visit www.bcbsnc.com/preventive for the most up-to-date federally-mandated PREVENTIVE CARE services, including those available for DEPENDENT CHILDREN. 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 a MEMBER changes PROVIDERS during pregnancy, terminates 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.

<table>
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<tr>
<th>Service</th>
<th>Description</th>
<th>Payment</th>
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<tr>
<td><strong>Prenatal care</strong></td>
<td>Care related to the pregnancy before birth</td>
<td>If seeing a PCP, a copayment may apply for the OFFICE VISIT to diagnose pregnancy. Deductible and coinsurance apply for the remainder of maternity care benefits.</td>
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<tr>
<td><strong>Labor &amp; delivery services</strong></td>
<td>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.</td>
<td>For the first 48/96 hours, only one admission copayment or BENEFIT PERIOD deductible is required for both mother and baby.</td>
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<tr>
<td><strong>Post-delivery services</strong></td>
<td>All care for the mother after the baby’s birth that is related to the pregnancy. PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours or services will be denied.</td>
<td>After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD, according to the rules in &quot;When Coverage Begins and Ends.&quot; For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required or services will be denied.</td>
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<tr>
<td></td>
<td></td>
<td>If the newborn must remain in the 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.</td>
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</table>

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

INFERTILITY Services
Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN. 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.
SEXUAL DYSFUNCTION Services

The PLAN provides benefits 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 and reversal of sterilization includes female tubal occlusion and male vasectomy. Reversal of sterilization is available for all MEMBERS. 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.

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 intrafallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
  - maternity for DEPENDENT CHILDREN, except as specifically covered by the PLAN
  - elective termination of pregnancy (abortion), except within the first 16 weeks of pregnancy for female SUBSCRIBERS and enrolled spouses of the SUBSCRIBERS 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
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

Specific Therapies and Tests

Therapy services are covered when provided for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

Home Infusion Therapy Services

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

BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. For more information about medical policies on INFERTILITY, visit BCBSNC's website at 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."
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.

**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, 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 are 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.

**ADAPTIVE BEHAVIOR TREATMENT**

This benefit is a non-essential health benefit. Benefits are provided for ADAPTIVE BEHAVIOR TREATMENT for MEMBERS up to age 19. Charges for ADAPTIVE BEHAVIOR TREATMENT from an inpatient or outpatient facility do not apply to the benefit maximum. Coverage includes assessments and treatment, which must be MEDICALLY NECESSARY, and ordered by a licensed physician or licensed psychologist. ADAPTIVE BEHAVIOR TREATMENT must be provided or supervised by the following professionals who are certified to provide this treatment:

- Licensed psychologist or psychological associate
- Licensed psychiatrist or developmental pediatrician
- Licensed speech and language pathologist
- Licensed occupational therapist
- Licensed clinical social worker
- Licensed professional counselor
- Licensed marriage and family therapist

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for ADAPTIVE BEHAVIOR TREATMENT or services will not be covered. Call Magellan at the number listed in "Who to Contact?" Visit our website at bcbsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a list of PROVIDERS.

**OTHER COVERED THERAPIES**

The PLAN covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment (three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY)
- 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.

**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 procedures, including but not limited to, CT scans, PET scans, MRIs, genetic and other lab testing and sleep studies (including associated DURABLE MEDICAL EQUIPMENT), may require PRIOR REVIEW and CERTIFICATION or services will not be covered. BCBSNC may delegate UTILIZATION MANAGEMENT of sleep studies to another company not associated with BCBSNC. See "Delegated UTILIZATION MANAGEMENT" for more information.

Your DOCTOR may refer you to a freestanding laboratory, radiology center, or a 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 the PLAN.

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
- Diagnostic tests used to confirm a known diagnosis or condition
- Tests used only for administrative purposes to measure process or quality improvement
- Tests that are duplicative or that are inclusive to other COVERED SERVICES
- Testing when a therapeutic or diagnostic course would not be determined by the outcome of the testing.

Other Services

Autism Spectrum Disorder Services
The PLAN provides coverage for the screening, diagnosis, and treatment of autism spectrum disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM-V") or any later edition. Coverage includes any MEDICALLY NECESSARY assessments, evaluations or tests to determine whether a MEMBER has autism spectrum disorder. If a MEMBER is diagnosed with autism spectrum disorder, coverage includes the following treatment or equipment related to the care of autism spectrum disorder, which must be MEDICALLY NECESSARY and ordered by a licensed physician or licensed psychologist:
- ADAPTIVE BEHAVIOR TREATMENT (see Specific Therapies and Tests for additional information)
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care (services provided by the following licensed professionals: speech therapist, occupational therapist, physical therapist, clinical social worker, professional counselor or marriage and family therapist)

Autism Spectrum Disorder Exclusion
- Services provided in a school setting, which includes: (i) services that are part of an individualized family service plan, an individualized education program, or an individualized service plan, or (ii) services performed by school personnel that are not part of an intensive behavioral plan prescribed by a licensed professional, including, but not limited to, school staff assistants, and shadow professionals.

Blood
The PLAN covers 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
The PLAN covers certain PROVIDER-ADMINISTERED SPECIALTY DRUGS that must be dispensed under a PROVIDER’S supervision in an office, outpatient setting, or through home infusion. PROVIDER-ADMINISTERED SPECIALTY DRUGS ordered or prescribed for a MEMBER by a PROVIDER must be adjudicated by the PLAN and 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, AMBULATORY SURGICAL CENTER or provided by a HOME HEALTH AGENCY). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit BCBSNC’s website at bcbsnc.com.

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

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

The PLAN provides benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, benefits for SURGERY will be subject to MEDICAL NECESSITY review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

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

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 the 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.

Dental Treatment Excluded Under Your Medical Benefit
Treatment for the following conditions:
- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor
And except as specifically stated as covered, treatment such as:
- Dental implants or root canals
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures
- Crowns, bridges, dentures or in-mouth appliances.

Temporomandibular Joint (TMJ) Services
The 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.

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

If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving surgical treatment for TMJ.

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.

Equipment and Supplies

DURABLE MEDICAL EQUIPMENT
Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a PROVIDER. Equipment may be purchased or rented at the discretion of the PLAN. The PLAN 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.

Hearing Aids
The PLAN provides coverage for MEDICALLY NECESSARY hearing aids, including implantable bone-anchored hearing aids (BAHA), and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER 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.

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 when custom-fit for the patient.

**Lymphedema-Related Services Exclusion**

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

**MEDICAL SUPPLIES**

Coverage is provided for MEDICAL SUPPLIES. Your benefits are based on where supplies are received, either as part of your MEDICAL SUPPLIES benefit or your PRESCRIPTION DRUG benefit. Select diabetic supplies and spacers for metered dose inhalers and peak flow meters are also covered under your PRESCRIPTION DRUG benefit.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on BCBSNC’s website at [bcbsnc.com](http://bcbsnc.com) or call BCBSNC Customer Service.

**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.

**PROSTHETIC APPLIANCES**

The PLAN provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCES must replace all or part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered.

**Surgical Benefits**

Surgical services by a professional or facility PROVIDER on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered.

Certain surgical procedures, including gender confirmation SURGERY and associated hormone therapy, and those surgical procedures that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Surgical benefits include, but are not limited to:

- Diagnostic SURGERY such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN
- Surgical treatment for morbid obesity (bariatric surgery) if you have received 12 months of medical management for this condition prior to the surgical procedure, supervised by your DOCTOR or OTHER PROFESSIONAL PROVIDER.
- Endovenous procedures used to support the normal functions of your veins, and sclerotherapy vein treatment

If you have more than one surgical procedure performed on the same date of service, those procedures 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 BCBSNC's website at bchsnc.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.

**Transplants**

The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed up to a $10,000 maximum per transplant based on BCBSNC guidelines that are available upon request from a transplant coordinator.

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.

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 up to a maximum of $10,000 per transplant.
- 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 are 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.

**Blue Distinction® Centers**

You may want to go to a Blue Distinction Center to receive your surgical procedure. Blue Distinction Centers are HOSPITALS and health care facilities with proven track records for delivering outstanding quality of care, service, and patient safety in the following specialties:

- bariatric surgery
- cardiac care
- complex and rare cancers
- knee or hip replacement
- transplants
- spine surgery

Visit [https://www.bcbs.com/blue-distinction-center-finder](https://www.bcbs.com/blue-distinction-center-finder) to find a Blue Distinction Center near you.
Mental Health and Substance Abuse Services
The PLAN provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, RESIDENTIAL TREATMENT FACILITY, DOCTOR or OTHER PROVIDER and includes, but is not limited to:

- OFFICE VISIT services
- Outpatient services (includes partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week), and intensive therapy services (less than four hours per day and minimum of nine hours per week)
- Inpatient and RESIDENTIAL TREATMENT FACILITY services (includes room and board and detoxification to treat substance abuse).

How to Access Mental Health and Substance Abuse Services
Your coverage for inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. PRIOR REVIEW by Magellan Behavioral Health is not required for any OFFICE VISIT services or in EMERGENCY situations; however, please notify Magellan Behavioral Health of an EMERGENCY inpatient admission as soon as reasonably possible.

PRIOR REVIEW and CERTIFICATION are required for inpatient (including RESIDENTIAL TREATMENT FACILITY services) or certain outpatient services, such as partial hospitalization and intensive therapy or services will not be covered. To request PRIOR REVIEW, call a Magellan Behavioral Health customer service representative at the number listed in "Who to Contact?" The Magellan Behavioral Health customer service representative can also help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements. See “PRIOR REVIEW (Pre-Service)” in UTILIZATION MANAGEMENT” for additional information.

Mental Health and Substance Abuse Services Exclusion
- Counseling with relatives about a patient.

PRESCRIPTION DRUG Benefits
Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including self-administered injectable medications, and contraceptive drugs and devices
- Certain preventive over-the-counter drugs when listed as covered in the FORMULARY, or under the PREVENTIVE CARE benefit, and a PROVIDER'S PRESCRIPTION for that drug is presented at the pharmacy (see “Summary of Benefits”)
- Immunizations for influenza, shingles, and pneumonia are covered at no cost to you when received at an IN-NETWORK pharmacy. The list of covered immunizations may change from time to time, call BCBSNC Customer Service for the most up-to-date list.
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity
- Insulin and diabetic supplies, such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

Benefits vary for MEDICAL SUPPLIES, depending on whether supplies are received at a MEDICAL SUPPLY PROVIDER or at a pharmacy. See "Summary of Benefits."

- Certain PRESCRIPTION DRUGS related to treatment of INFERTILITY.

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

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<th>Situation</th>
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<tr>
<td>Situation</td>
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<td>file a claim. You will be reimbursed the ALLOWED AMOUNT less any applicable deductible, coinsurance or copayment. Any charges over the ALLOWED AMOUNT are your responsibility. If you had an EMERGENCY or URGENT CARE condition and went to an OUT-OF-NETWORK pharmacy, call BCBSNC Customer Service at the number listed in &quot;Who to Contact?&quot; so that the claim will be processed at the IN-NETWORK level.</td>
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<td>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 (e.g., 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 the higher tiers (Tier 3 and Tier 4). All tiers of the FORMULARY may contain GENERIC and BRAND-NAME PRESCRIPTION DRUGS. SPECIALTY DRUGS, if applicable, are located on the highest tiers of the PLAN, even though they may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR PRESCRIPTION DRUGS. Visit BCBSNC's website at 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 in 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.</td>
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<tr>
<td>In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two different strengths of that drug to be dispensed. In these cases, 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 to three copayments depending on the quantity you receive. 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 BCBSNC's website at bcbsnc.com for a listing of retail pharmacies or a 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.</td>
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<td>Situation</td>
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</table>
| If you have multiple PRESCRIPTIONS and need to align your refill dates | If you have multiple PRESCRIPTIONS and need to align your refill dates you may need a PRESCRIPTION for less than a 30-day supply. If your DOCTOR or pharmacy agrees to give you a PRESCRIPTION for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for drugs covered under your PRESCRIPTION DRUG benefit, received at an IN-NETWORK pharmacy, and when PRIOR REVIEW requirements have been met. In addition, the drugs must:  
- be used for treatment and management of chronic conditions and are subject to refills;  
- NOT be a Schedule II or Schedule III controlled substance containing hydrocodone;  
- be able to be split over short-fill periods; and  
- not have quantity limits or dose optimization criteria that would be affected by aligning refill dates.  

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. |
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<tr>
<td>PRIOR REVIEW Requirements</td>
<td>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.</td>
</tr>
<tr>
<td>SPECIALTY DRUGS</td>
<td>BCBSNC has a separate pharmacy vendor for purchasing select SPECIALTY DRUGS. These SPECIALTY DRUGS (which include specialty GENERIC or BRAND-NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS) must be dispensed by the specialty pharmacy vendor in order to receive IN-NETWORK benefits. These drugs are limited to a one-month supply or less. For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit BCBSNC's website at bcbsnc.com.</td>
</tr>
<tr>
<td>RESTRICTED-ACCESS DRUGS and Devices</td>
<td>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.</td>
</tr>
<tr>
<td>Quantity Limitations</td>
<td>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.</td>
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</table>
Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include:
- the amount dispensed per PRESCRIPTION, per day, or per defined time period;
- the amount dispensed per lifetime; per month's supply; or
- the amount dispensed per single copayment, if applicable.

Note: excess quantities are not covered.
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?" The 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 PLAN
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an EMPLOYER, a mutual benefit association, labor union, trust or similar person or group
- Services 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, the 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 a claim form, 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, also 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 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 scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, skin tone enhancements, electrolysis, and SURGERY for psychological or emotional reasons, except as specifically covered by the PLAN

Services received either before or after the coverage period of the 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 appliances, except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics, except as specifically covered by the PLAN

DENTAL SERVICES provided in a HOSPITAL, except as described in "Dental Treatment Covered Under Your Medical Benefit"

The following drugs:

- A PRESCRIPTION DRUG that is in excess of the stated quality limits
- A PRESCRIPTION DRUG that is purchased to replace a lost, broken, or destroyed PRESCRIPTION DRUG except under certain circumstances during a state emergency or disaster
- A PRESCRIPTION DRUG that is any portion or refill which exceeds maximum supply for which benefits will be provided when dispensed under any one PRESCRIPTION
- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required
- EXPERIMENTAL drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS (1) specifically listed as covered drug in the FORMULARY and a written prescription is provided or (2) 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 Thomson Micromedex® 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.

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
- A PRESCRIPTION DRUG that is compounded and does not contain at least one ingredient that is defined as a PRESCRIPTION DRUG (see Glossary). Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage
- A PRESCRIPTION DRUG that is contraindicated (should not be used) due to age, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA’s approved product labeling.
- A medical device, unless specifically listed as a covered medical device in the FORMULARY and written PRESCRIPTION is provided.
- A medication that has been repackaged – a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

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 the PLAN

The following equipment:

- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
WHAT IS NOT COVERED? (cont.)

- 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
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, or pools
- Personal computers
- Standing frames.

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 the PLAN.

F
ROUTINE FOOT CARE that is palliative or COSMETIC

G
Genetic testing, except for high risk patients when the identification of a genetic abnormality correlates with the likelihood of a disease or condition, and when the therapeutic or diagnostic course would be determined by the outcome of the testing. Please see https://www.bcbsnc.com/content/services/medical-policy/index.htm and click on the link for [name] for a description of genetic tests that are not covered as part of the PLAN.

H
Routine hearing examinations and hearing aids, including implantable bone-anchored hearing aids (BAHA), or examinations for the fitting of hearing aids for MEMBERS over the age of 22.

Home Health Care
Care provided in the home, including, but not limited to: homemaker services, such as cooking, housekeeping, and food or meal preparation; dietitian services or meals; services that are provided by a close relative or a member of your household.

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 the PLAN.

M
Services or supplies deemed not MEDICALLY NECESSARY or not ordered by a PROVIDER

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 the PLAN.

O
The following obesity services
- Any cost associated with membership in weight management program or health club
- Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a MEMBER or for treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by the PLAN.

P
Body piercing
WHAT IS NOT COVERED? (cont.)

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

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 mental health and substance abuse treatment) or any similar facility or institution

RESPITE CARE, whether in the home or in a facility or inpatient setting, except as specifically covered by the PLAN

Services or supplies that are:
- Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER
- Available to a MEMBER without charge.

SEXUAL DYSFUNCTION not due to organic disease

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

The following types of Temporomandibular Joint (TMJ) Services:
- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions

The following types of therapy:
- Music therapy, recreational or activity therapy, and all types of animal therapy. Remedial reading and all forms of special education and supplies or equipment used similarly, except as specifically covered by the PLAN
- Massage therapy
- Cognitive therapy
- Group classes for pulmonary rehabilitation.

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

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
- Orthoptics, vision training, and low vision aids
- Lenses for keratoconus or any other eye procedure except as specifically covered under the PLAN.

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

W
Wigs, hairpieces and hair implants for any reason, except as specifically covered by the PLAN
To be covered under the PLAN, you must be an active full-time EMPLOYEE who works 30 or more hours per week. However, your EMPLOYER may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins. You may also be eligible for coverage under the PLAN if the PLAN ADMINISTRATOR allows eligibility to extend to other persons, such as retirees.

For DEPENDENTS to be covered under the 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 or your spouse's DEPENDENT CHILDREN through the end of the month of their 26th birthday. Your EMPLOYER may require proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in the "Glossary."
- A DEPENDENT CHILD who, in accordance with North Carolina law, is and continues to be either intellectually disabled or physically handicapped and incapable of self-support may continue to be covered under the 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 the PLAN.

Enrolling in the PLAN

It is very important to consider when you apply for coverage and/or add DEPENDENTS. Your EMPLOYER allows you to apply for or make changes to your coverage during the annual enrollment period, which is held once a year. If you do not apply for coverage within 30 days of when you or your DEPENDENTS first become eligible, you will have to wait for a future annual enrollment period. Newly eligible children (newborns, adoptive children, or FOSTER CHILDREN) and children added as a result of a court order, such as a Qualified Medical Child Support Order (QMCSO), are not restricted to the annual enrollment period.

You may also apply for coverage and/or add DEPENDENTS within a 30-day period following any of the triggering/qualifying events (hereafter referred to as "triggering events") listed below unless otherwise noted. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered triggering events:

- You or your DEPENDENTS become eligible for coverage under the PLAN
- You get married or obtain a DEPENDENT through birth, court order, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
  - you and/or your DEPENDENTS are otherwise eligible for coverage under the PLAN, and
  - you and/or your DEPENDENTS were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
  - you and/or your DEPENDENTS lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of DEPENDENT status, death of the EMPLOYEE, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination
of EMPLOYER contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.

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

**Adding or Removing a DEPENDENT**

Do you want to add or remove a DEPENDENT? You must notify the PLAN ADMINISTRATOR and fill out any required forms. For coverage to be effective on the date the DEPENDENT becomes eligible, any forms must be completed within 30 days after the DEPENDENT becomes eligible.

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

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

**Qualified Medical Child Support Order**

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

**Types of Coverage**

These are the types of coverage available:

- **EMPLOYEE-only coverage**-The PLAN covers only you
- **EMPLOYEE-child coverage**-The PLAN covers you and one DEPENDENT CHILD
- **Family coverage**-The PLAN covers you, your spouse and your DEPENDENT CHILDREN.

**Reporting Changes**

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

**Continuing Coverage**

Under certain circumstances, your eligibility for coverage under this PLAN may end.

You may have certain options such as enrolling in Medicare or continuing health insurance under this PLAN. Coverage available during a leave of absence varies depending on the type of leave you take and your EMPLOYER'S leave of absence policy. Contact your Human Resources department for more information.

**Medicare**

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

If you are covered by this PLAN when you become eligible for Medicare, consult the PLAN ADMINISTRATOR, who will advise you about continuation of coverage under the PLAN.
Continuation Under Federal Law

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

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

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

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

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

If you are a retired employee and your employer allows coverage to extend to retirees under this plan, and you, your spouse, or your dependents lose coverage resulting from a bankruptcy proceeding against your employer, you may qualify for continuation coverage under COBRA. Contact the plan administrator for conditions and duration of continuation coverage.

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

You or your dependents must notify the plan administrator within 60 days of the following triggering events:

- Divorce
- Ineligibility of a dependent child.

You and/or your dependents will be offered continuation coverage within 14 days of the date that the COBRA administrator is notified of one of these events resulting in the termination of your coverage. Eligible persons have 60 days to elect or reject continuation coverage. Following election, applicable fees must be paid to the COBRA administrator within 45 days.

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

- Your employer ceases to provide a health benefit plan to employees
- The continuing person fails to pay the monthly fee on time
- The continuing person obtains coverage under another group plan
- The continuing person becomes entitled to Medicare after the election of continuation coverage.

If you are covered by the plan and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult the plan administrator. The plan administrator will advise you about the continuation of coverage if required under USERRA.

If you have any questions about your COBRA rights or continuation of coverage, please contact the plan administrator.

Certificate of Creditable Coverage

The plan administrator or its designee will supply a certificate of creditable coverage when your or your dependent’s coverage under the plan ends or you exhaust continuation of coverage. 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 the plan and up to 24 months following your termination.

You may call BCBSNC Customer Service at 1-877-275-9787 (toll-free), or visit BCBSNC website at bcbsnc.com.
Termination of MEMBER Coverage

BCBSNC will terminate coverage under the PLAN in accordance with eligibility information provided by the EMPLOYER. A MEMBER's termination shall be effective at 11:59 p.m. on the date that eligibility ends.

Termination for Cause

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

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

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

A MEMBER'S coverage under the PLAN will be terminated immediately for the following reasons:

- Fraud or intentional misrepresentation of a material fact by a MEMBER or DEPENDENT. 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 "Need to Appeal a Decision?" If your policy is rescinded, any premiums paid will be returned unless BCBSNC deducts the amount for any claims paid.
- A MEMBER has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A MEMBER permits the use of his or her or any other MEMBER'S ID CARD by any other person not enrolled under this PLAN, or uses another person's ID CARD.
This Section provides information on how certain services are reviewed to determine if they are MEDICALLY NECESSARY.

### Table of Contents:
- Rights and Responsibilities
- Prior Review
- Concurrent/Retrospective Review
- Care Management
- Continuity of Care
- Delegated UTILIZATION MANAGEMENT

### Key Words:
- ADVERSE BENEFIT DETERMINATION
- MEDICALLY NECESSARY
- CERTIFICATION
- PRIOR REVIEW

To make sure you can have high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires certain health care services to 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, given in the proper setting and for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under the PLAN unless the CERTIFICATION was based on:

- A material misrepresentation about your health condition
- You were not eligible for these services under the PLAN due to cancellation of coverage (including your voluntary termination of coverage)
- 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, along with an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director (doctor licensed in North Carolina) from BCBSNC make a final decision of all NONCERTIFICATIONS
- Request a review of an ADVERSE BENEFIT DETERMINATION through the appeals process (see "Need to Appeal a Decision?")
- Have an authorized representative seek 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 name an authorized representative, “you” under the “UTILIZATION MANAGEMENT” sections means “you or your authorized representative.” Your representative will also receive all notices and benefit determinations.

#### BCBSNC’s Responsibilities

As part of all UM decisions, BCBSNC will:

- Give you and your PROVIDER a toll-free phone number to call UM review staff when CERTIFICATION of a health care service is needed. See "Who to Contact?"
- Limit what BCBSNC asks from you or your PROVIDER to information that is needed to review the service in question
- Ask for all information needed to make the UM decision, including related clinical information
- Give you and your PROVIDER timely notification of the UM decision consistent with applicable state and federal law and the PLAN.

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

### PRIOR REVIEW (Pre-Service)

Certain services require PRIOR REVIEW as noted in “COVERED SERVICES.” These types of reviews are called pre-service reviews.

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. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC. The PLAN delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan
Behavioral Health is not associated with BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a full denial of benefits.**

If PRIOR REVIEW is required by the PLAN, you or your PROVIDER must request PRIOR REVIEW regardless of whether this PLAN is your primary or secondary coverage (see "Coordination of Benefits (overlapping coverage)"). Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION.

To request PRIOR REVIEW, please call the numbers in "Who to Contact?"

<table>
<thead>
<tr>
<th>General categories of services with this requirement are noted in &quot;COVERED SERVICES.&quot; The list of services that need PRIOR REVIEW may change from time to time. For a detailed list of these services and the most up-to-date information visit BCBSNC website at bcbsnc.com or call BCBSNC's Customer Services at the number listed in &quot;Who to Contact?&quot;</th>
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If you fail to follow the procedures for filing a request for CERTIFICATION, BCBSNC will let you know of the failure and the proper steps 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. However, it will be no later than 15 calendar 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 BCBSNC will let you and your PROVIDER know 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 let you and the PROVIDER know 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 life, health, or safety or the life, health or safety of others, due to your psychological state, or (ii) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request. BCBSNC will let you and your PROVIDER know 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 given to you and your PROVIDER.

If BCBSNC needs more information to process your urgent review, BCBSNC will let you and your PROVIDER know of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You 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 on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the PROVIDER to submit necessary clinical information, whichever comes first.

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 PROVIDER within three business days after receipt of all necessary clinical information, but no later than 15 calendar days after we receive the request.

In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will let you, your HOSPITAL’S or other facility’s UM department and/or your PROVIDER know within three business days after receipt of all necessary clinical information, but no later than 15 calendar 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 given to the requesting HOSPITAL or other facility as soon as possible. However, the decision will be 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 concurrent review, BCBSNC will let the requesting HOSPITAL or other facility know 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 24 hours, to provide the requested information. BCBSNC will make a decision within 72 hours after receipt of the request.

**Retrospective Reviews (Post-Service)**

BCBSNC also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to see if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and let you and your PROVIDER know 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 let you and your PROVIDER know in writing within a reasonable time but not later than 30 calendar days from the date BCBSNC received the request. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this PLAN. If more information is needed before the end of the initial 30-day period, BCBSNC will let you know of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC gets the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 calendar 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 the 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 (case management as well as disease management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and the PLAN 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. The PLAN is not obligated to give the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be found by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

In addition to our care management programs for MEMBERS with complicated and/or chronic medical needs, MEMBERS may receive a reduced or waived out of pocket costs in connection with programs and/or promotions. These are designed to encourage members to seek appropriate, high quality, efficient care based on BCBSNC criteria.

**Continuity of Care**

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for ongoing special conditions at the IN-NETWORK benefit level when the MEMBER or EMPLOYER changes plans or when your PROVIDER is no longer in the PPO network.

If your PCP or SPECIALIST leaves the BCBSNC PROVIDER network and they are currently treating you for an ongoing special condition that meets BCBSNC 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, the MEMBER must be actively being seen by the OUT-OF-NETWORK PROVIDER.
for an ongoing special condition and the PROVIDER must agree to abide by the BCBSNC requirements for continuity of care.

An ongoing special condition means:

- 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;
- 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;
- pregnancy during the second and third trimesters;
- 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 decided by the PROVIDER, except in the cases of:

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

Continuity of care requests must be submitted to BCBSNC within 45 days of the provider termination date or within 45 days or effective date for members new to BCBSNC plan. Continuity of care requests will be reviewed by a medical professional based on the information given about specific medical conditions. If your continuity of care request is denied, you may request a review through our appeals process (see “Need to Appeal a Decision?”). Claims for approved continuity of care services will be subject to the 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 given 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 certain UM services for particular benefits to other companies not associated with BCBSNC. Please see https://www.bcbsnc.com/content/services/medical-policy/index.htm for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES, " the list of benefits and/or companies may change from time to time; for the most up-to-date information visit bcbsnc.com and search for “PRIOR REVIEW” for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION.
NEED TO APPEAL A DECISION?

This section tells you more about how to the appeal process works and what steps you need to take to file an appeal.

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In addition to the UTILIZATION MANAGEMENT (UM) program, BCBSNC offers a voluntary appeals process for MEMBERS. An appeal is another review of your case.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, or have a GRIEVANCE you can request that BCBSNC review the decision or GRIEVANCE. The process 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 name an authorized representative, "you” under this section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations from the appeal.

You may also ask for at no charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. Mental Health and Substance Abuse as well as Dental appeals have been delegated to third party vendors. Please see the end of this section for contact information. References to BCBSNC throughout this section refer to BCBSNC or the designee.

Steps to Follow in the Appeals Process

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

Any request for review should include:

- MEMBER’S ID number
- MEMBER’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 BCBSNC’s website at BlueConnectNC.com or call BCBSNC Customer Service at the number given in “Who to Contact?”

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

BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

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

After a request for review, a staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case information before. 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 about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall seek advice from a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC). The health care professionals have not reviewed your case or information before.

You will have exhausted the PLAN’S internal appeals process after pursuing a first level appeal. Unless specifically noted below, upon completion of the first level appeal you may: pursue a second level appeal; or pursue a civil action under 502(a) of ERISA. You will be deemed to have exhausted the PLAN’S internal appeals process at any time it is determined that BCBSNC failed to strictly adhere to all claim determinations and appeal requirements under Federal law (other than minor errors that are not likely to cause prejudice or harm to you and were for good cause or situation beyond BCBSNC’s
control). In the event you are deemed to have exhausted the PLAN’s internal appeal process, and unless specifically noted below, you may pursue an external review.

**Timeline for Appeals**

For appeals about an ADVERSE BENEFIT DETERMINATION, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date listed on your Explanation of Benefits.

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<td>72 hours after receipt- Oral 4 days after receipt of request - Written</td>
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**First Level Appeal**

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

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

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

**Second Level Appeal**

**Second Level Appeal Timeline**

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

- Name, address and phone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive all information that applies to your appeal from BCBSNC
  - take part in the second level appeal 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
  - pursue other voluntary alternative dispute resolution options as applicable.

The second level appeal meeting, will be conducted by a review panel arranged by BCBSNC. The panel will include external physicians and/or benefit experts. This will be held within 45 days after BCBSNC receives a second level appeal request. BCBSNC will give you notice of the meeting date and time at least 15 days before the meeting. The
meeting will be held by teleconference. You have the right to a full review of your appeal even if you do not take part in the meeting. A written decision will be issued to you within seven business days of the review meeting.

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

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER's claim for benefits upon request at no additional cost
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER's right to receive information about the procedures as well as the MEMBER's right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision upon request at no charge
- Instructions on how to request an external, independent review from an independent review organization (IRO) upon completion of this review if not satisfied with the decision (available for NONCERTIFICATIONS only)
- The right to pursue other voluntary alternative dispute resolution options as applicable
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the PLAN to the MEMBER's medical circumstances, or a statement that such explanation will be provided at no cost upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

**Expedited Appeals (Available only for NONCERTIFICATIONS)**
You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT's life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. To start the process of an expedited appeal, you can call 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 first level or second level 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. The decision will be communicated 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.

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

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

Second level appeal, if eligible, is provided by BCBSNC.

**Quality of Care Complaints**
For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.
This section provides information on:

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### Benefits to which MEMBERS are Entitled

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under the PLAN, and the right to enforce any claim arising under the PLAN cannot be transferred or assigned to any other person or entity, including PROVIDERS. PROVIDERS are not considered beneficiaries under the PLAN and do not have standing to sue under ERISA. Under the PLAN, 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 the PLAN. Under the PLAN, BCBSNC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the 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 EMPLOYEE, the PLAN 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 EMPLOYEE or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER.

Benefits for COVERED SERVICES specified in the PLAN will be provided only for services and supplies that are performed by a PROVIDER as specified in the 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 the PLAN.

Any amounts paid by the PLAN for noncovered services or that are in excess of the benefit provided under your Blue Options 1-2-3 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.

Amounts paid by the PLAN for work-related accidents, injuries, or illnesses covered under state workers’ compensation laws will be recovered 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 (whomever 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 Disclosure of Protected Health Information (PHI)

The privacy of your protected health information is very important. BCBSNC will only use or disclose your protected health information in accordance with applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).
Administrative Discretion
BCBSNC has the authority to use its discretion 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 when making coverage determinations.

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

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options 1-2-3 MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Blue Options 1-2-3 ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

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

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all DENTAL SERVICES (unless provided under your medical benefits), PRESCRIPTION DRUG or vision care benefits that may be administered by a third party contracted by BCBSNC to provide the specific service or services.

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

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

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the "Host Blue" passes on to BCBSNC.

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 health care services according to applicable law.
As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the lower of the participating PROVIDER's billed covered charges or negotiated price made available to BCBSNC by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, are made available to you, you will be responsible for the amount that the healthcare PROVIDER bills above the specific reference benefit limit for the given procedure. For a participating PROVIDER, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating PROVIDER, that amount will be the difference between the PROVIDER’S billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a PROVIDER’S billed charge, you will incur no liability, other than any related patient cost sharing under this PLAN.

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

Value-Based Programs: BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSNC through average pricing or fee schedule adjustments.

Value Based Programs: Negotiated (non-BlueCard Program) Arrangements

If BCBSNC has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to your EMPLOYER on your behalf, BCBSNC will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Blue Cross Blue Shield Global Core:

If you are outside the United States (hereinafter “BlueCard service area”), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing COVERED SERVICES. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional PROVIDERS, the network is not served by a Host Blue. As such, when you receive care from PROVIDERS outside the BlueCard service area, you will typically have to pay the PROVIDERS and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

● Inpatient Services

In most cases, if you contact the service center for assistance, HOSPITALS will not require you to pay for covered inpatient services, except for any applicable copay, deductible or coinsurance amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for COVERED SERVICES. You must contact BCBSNC to obtain precertification for non-emergency inpatient services.

● Outpatient Services

Physicians, URGENT CARE centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for COVERED SERVICES.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for COVERED SERVICES outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a claim form and send the claim form with the PROVIDER’S itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following
the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNC, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

**Right of Recovery Provision**

The provisions of this section apply to all current or former PLAN participants and also to the parents, guardian, or other representative of a DEPENDENT CHILD who incurs claims and is or has been covered by the PLAN. The PLAN’S right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. “MEMBER” includes anyone on whose behalf the PLAN pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the PLAN.

As used throughout this provision, the term “responsible party” means any party possibly responsible for making any payment to a MEMBER due to a MEMBER’S injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers’ compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The PLAN is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the PLAN’S subrogation and reimbursement interest are fully satisfied.

The right of subrogation means the PLAN is entitled to pursue any claims that the MEMBER may have in order to recover the benefits paid by the PLAN. Immediately upon paying or providing any benefit under the PLAN, the PLAN shall be subrogated to all rights of recovery a MEMBER has against any party potentially responsible for making any payment to a MEMBER due to a MEMBER’S injuries, illness or condition, to the full extent of benefits provided or to be provided by the PLAN. The PLAN may assert a claim or file suit in the MEMBER’S name and take appropriate action to assert its subrogation claim, with or without your consent. The PLAN is not required to pay the MEMBER part of any recovery it may obtain, even if it files suit in the MEMBER’S name.

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the PLAN has the right to recover from, and be reimbursed by, the MEMBER for all amounts the PLAN has paid and will pay as a result of that injury or illness, up to and including the full amount the MEMBER receives from all potentially responsible parties. The MEMBER agrees that if the MEMBER receives any payment from any potentially responsible party as a result of an injury or illness, the MEMBER will serve as a constructive trustee over the funds for the benefit of the PLAN. Failure to hold such funds in trust will be deemed a breach of the MEMBER’S fiduciary duty to the PLAN. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the PLAN’S subrogation and reimbursement interest are fully satisfied.

Further, the PLAN will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a MEMBER receives from the third party, the third party’s insurer or any other source as a result of the MEMBER’S injuries. The lien is in the amount of benefits paid by the PLAN for the treatment of the illness, injury or condition for which another party is responsible.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the PLAN including, but not limited to, the MEMBER; the MEMBER’S representative or agent; responsible party; responsible party’s insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the PLAN. In order to secure the PLAN’S recovery rights, the MEMBER agrees to assign to the PLAN any benefits or claims or rights of recovery they have under any automobile policy or other coverage, to the full extent of the PLAN’S subrogation and reimbursement claims. This assignment allows the PLAN to pursuit any claim the MEMBER may have, whether or not they choose to pursue the claim.

The MEMBER acknowledges that the PLAN’S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the PLAN before any other claim for the MEMBER’S damages. The PLAN shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the PLAN will result in a recovery to the MEMBER which is insufficient to make the MEMBER whole or to compensate the MEMBER in part or in whole for the damages sustained. It is further understood that the PLAN is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER to pursue their damage claim.
The terms of this entire right of recovery provision shall apply and the PLAN is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the MEMBER identifies the medical benefits the PLAN provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The PLAN is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages and/or general damages only. The PLAN’s claim will not be reduced due to your own negligence.

The MEMBER acknowledges that BCBSNC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with BCBSNC’s efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify BCBSNC in writing of the MEMBER’s intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER and their agents agree to provide the PLAN or its representatives notice of any recovery the MEMBER or the MEMBER’S agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the MEMBER and the MEMBER’S agents shall provide notice prior to any disbursement of settlement or any other recovery funds obtained. The MEMBER shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request and all documents related to or filed in personal injury litigation.

The MEMBER shall do nothing to prejudice the PLAN’s recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the PLAN.

The MEMBER acknowledges that the PLAN has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The PLAN reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The MEMBER acknowledges that the PLAN has notified them that it has the right pursuant to the Health Insurance Portability & Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the MEMBER and the PLAN agree that the PLAN ADMINISTRATOR shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The MEMBER agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the PLAN, the MEMBER hereby submits to each such jurisdiction, waiving whatever rights may correspond to the MEMBER by reason of the MEMBER’S present or future domicile. By accepting such benefits, the MEMBER agrees to pay all attorneys’ fees the PLAN incurs in successful attempts to recovery amounts the PLAN is entitled to under this section.

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

**Notice of Benefit Determination**
BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER’S authorized representative within 30 days of receipt of a notice of claim if the MEMBER has financial liability on the claim other than a copayment or other services where payment was made at the point of service (unless the PLAN has chosen to provide an explanation of benefits for additional claims where the MEMBER does not have a financial liability other than a copayment).

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

Such notice will be worded in an understandable manner and will include:
ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

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

Upon receipt of a denial of benefits, you have the right to file an appeal with BCBSNC. See "Need to Appeal a Decision?" for more information.

Limitation of Actions
If the PLAN is subject to ERISA, you must exhaust only the first level appeal process before bringing any legal action to recover benefits. **No legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process.** If you choose to pursue a second level appeal, the one-year period for bringing a legal action will begin to run once that final second-level decision has been issued.

If the PLAN is not subject to ERISA, no legal action may be brought to recover benefits until you have exhausted all administrative remedies, which requires completion of the two-level appeals process. No legal action may be taken later than three years from the date services are INCURRED.

Please see "Need to Appeal a Decision?" for details regarding the appeals process.

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 BCBSNC to determine the best services and products to offer MEMBERS. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from PROVIDERS who know the needs of the patients they serve.

Coordination of Benefits (Overlapping Coverage)
If a MEMBER is also enrolled in another group health plan, the PLAN may take into account benefits paid by the other plan.

Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. Payment by BCBSNC under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.

If you receive services from an OUT-OF-NETWORK PROVIDER, you are responsible for any charges not paid by either group insurance plan. You may wish to check with the primary group insurance plan to find out if an OUT-OF-NETWORK PROVIDER participates in the primary group insurance plan’s network and whether this affects your responsibility for paying up to the PROVIDER’S charges.
ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

If either the primary or the secondary health benefit plan covers a particular service, where the PLAN is the secondary plan, the PLAN will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service.

BCBSNC, on behalf of the PLAN may request information about the other plan from the MEMBER. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits from other group health plans are taken into account, benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

**Important Information for MEMBERS Eligible for Medicare**

If you are eligible for or enrolled in Medicare, the PLAN will determine Medicare primacy in accordance with the Medicare Secondary Payer rules and will coordinate benefits based on your Medicare eligibility. Information regarding how Medicare works with other insurance benefits like those offered by the PLAN can be found on [www.medicare.gov](http://www.medicare.gov).

If you or your DEPENDENTS are covered under the PLAN, and are eligible for Medicare, the PLAN may take into account the benefits that you or your DEPENDENTS 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, the PLAN may reduce a claim based on the benefits you are eligible for under Medicare, and then pay the remaining claim amount under the terms of the PLAN and in accordance with the Medicare Secondary Payer rules. As a result, if you are eligible for Medicare and Medicare would pay benefits primary to the PLAN, your out-of-pocket costs may be higher if you do not enroll in Medicare. The Medicare Secondary Payer rules that determine when Medicare pays benefits primary to other insurance benefits like those offered by the PLAN are complex and will not result in higher out-of-pocket costs in every instance. Therefore, if you become eligible for Medicare and are unsure about how the PLAN will coordinate benefits with Medicare, please contact your Plan Administrator for more information.

The rules by which a plan is determined primary or secondary are listed in the following chart. The "participant" is the person who is signing up for group health insurance coverage.

<table>
<thead>
<tr>
<th>When a person is covered by 2 group health plans, and</th>
<th>Then</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>One plan does not have a COB provision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan without the provision is</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>The plan with the provision is</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The person is the participant under one plan and a DEPENDENT under the other</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>The plan covering the person as the participant is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan covering the person as a DEPENDENT is</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>The person is covered as a DEPENDENT CHILD under both plans and parents are either:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) married or living together; or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD’S health care coverage; or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD’S health care coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*Note: When the parents have the same birthday, the plan that covered the parent longer is*  

<p>| The person is covered as a DEPENDENT CHILD under both plans and parents are |      |        |          |
|                          |      |        |          |
| The custodial parent’s plan is |      | ✓      |          |
| The plan of the spouse of the custodial parent is |      |        | ✓        |</p>
<table>
<thead>
<tr>
<th>When a person is covered by 2 group health plans, and</th>
<th>Then</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>divorced/separated or not living together with no court decree* for coverage</td>
<td>Or, if the custodial parent covers the child through their spouse’s plan, the plan of the spouse is</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The non-custodial parent’s plan is</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree*; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*</td>
<td>The plan of the parent primarily responsible for health coverage under the court decree is</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan of the other parent is</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Note: If there is a court decree that requires a parent to assume financial responsibility for the child’s health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent’s plan are</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>The person is covered as a laid-off or retired MEMBER or that MEMBER’S DEPENDENT on one of the plans, including coverage under COBRA</td>
<td>The plan that covers a person other than as a laid-off or retired MEMBER or as that MEMBER’S DEPENDENT is</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan that covers a person as a laid-off or retired MEMBER or the DEPENDENT of a laid-off or retired MEMBER is</td>
<td></td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person is the participant in two active group health plans and none of the rules above apply</td>
<td>The plan that has been in effect longer is</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan that has been in effect the shorter amount of time is</td>
<td></td>
<td>□</td>
</tr>
</tbody>
</table>

*Note: You may be required to submit a copy of the court order or legal documentation in these instances.
**Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

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

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

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

**Mastectomy Benefits**

Under the Women’s Health and Cancer Rights Act of 1998, the plan provides for the following services related to mastectomy surgery:

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

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

The benefits described above are subject to the same applicable deductibles, copayment or coinsurance and limitations as applied to other medical and surgical benefits provided under the plan.
Programs Outside Your Regular Benefits

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

- Health and wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Rewards or drawings for gifts based on activities related to online tools found on BCBSNC website
- Rewards or drawings for gifts based on participation in initiatives and/or programs to reduce health care costs
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the PLAN or BCBSNC, but may instead be arranged for your convenience. These discounts are outside the PLAN benefits. Neither the PLAN nor BCBSNC is 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 the PLAN benefits. Neither the PLAN nor BCBSNC is liable for third party PROVIDERS’ negligent provision of the gifts. The PLAN ADMINISTRATOR or BCBSNC may stop or change these programs at any time.

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 provide the opportunity to work one-on-one with a specially trained nurse, and offer benefits for MEMBERS with certain conditions who agree to engage. 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 telephonic coaching and 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, telephonic 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 BCBSNC’s website at bchsnc.com. Programs are available at the discretion of your EMPLOYER. To determine which programs are available to you, log into BlueConnectNC.com. You can also call 1-800-260-0091 to learn more about these programs and find out which ones are included in the PLAN.

**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.
These definitions will help you understand the PLAN. Please note that some of these terms may not apply to the PLAN.

**ADAPTIVE BEHAVIOR TREATMENT**
Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. All services performed must be within the PROVIDER’S scope of license or certification to be eligible for reimbursement.

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

**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, URGENT CARE, and Ambulance Services" 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 through the BlueCard system 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 an amount 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. Other than described above, BCBSNC will not pay the OUT-OF-NETWORK PROVIDER’s billed charge unless doing so is required in order to comply with North Carolina Statutes. 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.

**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 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 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 the PLAN. 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.
GLOSSARY (cont.)

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 has 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 BCBSNC’s requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

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

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

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

COVERED SERVICE(S)
A service, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of the 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 EMPLOYEE as specified in "When Coverage Begins and Ends."

DEPENDENT CHILD(REN)
A child until the end of the month of their 26th birthday, who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse, or 3) a child for whom the EMPLOYEE and/or spouse has been court-ordered to provide coverage. The spouse 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 which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

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.

EMPLOYEE
The person who is eligible for coverage under the PLAN due to employment with the EMPLOYER and who is enrolled for coverage.

EMPLOYER
ASO BO123 Copay BH

ERISA

ESSENTIAL HEALTH BENEFITS
The core set of services as defined by federal law that 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 any clerk of superior court, 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 which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:
   a) Provides skilled nursing and other services on a visiting basis in the MEMBER’S home,
   b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,
   c) Is accredited and licensed or certified in the state where located,
   d) Is certified for participation in the Medicare program, and
   e) Is acceptable to BCBSNC.

HOSPICE
A NONHOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:
   a) Is accredited, licensed or certified in the state where located,
   b) Is certified for participation in the Medicare program, and
   c) Is acceptable to BCBSNC.

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

IDENTIFICATION CARD (ID CARD)
The card issued to MEMBERS upon enrollment which provides EMPLOYER/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 PPO network. BCBSNC’s payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER
A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a Blue Options 1-2-3 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 the 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 that will be reimbursed on behalf of a MEMBER while covered under the 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. See "Summary of Benefits" for any limits that may apply.

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 the 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
An EMPLOYEE or DEPENDENT, who is currently enrolled in the 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, in accordance with North Carolina law, a mental condition, other than intellectual disability 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 autism spectrum disorder, substance-related disorders, SEXUAL DYSFUNCTION not due to organic disease, and those coded as “V” codes are not included in the definition of mental illness.

NONCERTIFICATION
An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under the 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
Services provided in a PROVIDER'S office, including, but not limited to the following:

- Medical care
- SURGERY
- Diagnostic Services
- REHABILITATIVE and HABILITATIVE THERAPY services
- MEDICAL SUPPLIES
- Mental health and substance abuse services (evaluation and diagnosis, group therapy, individual and family counseling).

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, which is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

a) Cardiac rehabilitative therapy—reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy)—the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the 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 PPO network, and not certified in advance by BCBSNC to be considered as IN-NETWORK. Payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER
A PROVIDER that has not been designated as a Blue Options 1-2-3 PROVIDER by BCBSNC.

OUT-OF-POCKET LIMIT
The maximum amount listed in “Summary of Benefits” that is payable by the MEMBER in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES. It includes deductible, coinsurance, and any applicable copayments.

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

PLAN
The EMPLOYER health benefit plan established by ASO BO123 Copay BH to provide health benefits for participants.

PLAN ADMINISTRATOR
ASO BO123 Copay BH

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.

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.

PROVIDER-ADMINISTERED SPECIALTY DRUGS
SPECIALTY DRUGS that are available on the medical benefit typically require close PROVIDER supervision and are generally dispensed in an office, outpatient setting, or through an infusion agency.

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
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 a body part

c) Speech therapy—treatment for the restoration of speech impaired by disease, SURGERY, or injury; certain significant physical CONGENITAL conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

RESIDENTIAL TREATMENT FACILITY
A residential treatment facility 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.

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 self-administered or PROVIDER-administered and 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 person who is eligible for coverage under this health benefit plan due to employment and who is enrolled for coverage.

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

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 higher-cost PRESCRIPTION DRUGS, most are BRAND-NAME PRESCRIPTION DRUGS, and some SPECIALTY DRUGS.

TIER 4 DRUGS
The PRESCRIPTION DRUG tier which consists of the highest-cost PRESCRIPTION DRUGS, most are SPECIALTY drugs.

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

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

WAITING PERIOD
The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of the PLAN.
ERISA Rights Statement

As a participant in the PLAN, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all MEMBERS shall be entitled to:

- Examine, without charge, at the PLAN ADMINISTRATOR'S office and at other specified locations, such as worksites, all PLAN documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the PLAN with the U.S. Department of Labor.
- Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the PLAN, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary PLAN Descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.
- Receive a summary of the PLAN'S financial report. The PLAN ADMINISTRATOR is required by law to furnish each MEMBER with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or DEPENDENTS if there is a loss of coverage under the PLAN as a result of a qualifying event. You or your DEPENDENTS may have to pay for such coverage. Review this Summary Plan Description and the documents governing the PLAN on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for MEMBERS, ERISA imposes duties upon the people who are responsible for the operation of the PLAN. The people who operate the PLAN, called "fiduciaries" of the PLAN, have a duty to do so prudently and in the interest of you and other PLAN MEMBERS and beneficiaries. No one, including your EMPLOYER or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the PLAN and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the PLAN ADMINISTRATOR. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the PLAN'S decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the PLAN fiduciaries misuse the PLAN'S money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the PLAN, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
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 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 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.
Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

• Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

• BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:

□ Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

□ Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

• If you need these services, contact Customer Service 1-888-206-4697, TTY and TDD, call 1-800-442-7028.

• If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783 civilrightscoordinator@bcbsnc.com

• You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.


• This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service 1-888-206-4697.
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).


注意: 如果您講廣東話或普通話，您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY : 1-800-442-7028)。

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。


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Group Effective Date:
January 1, 2018

An Independent Licensee of the Blue Cross and Blue Shield Association
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