

Benefit Booklet
For Team Members of
Family Dollar Stores, Inc.
for

Blue OPTIONSSM

PPO CORE PLAN



An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes the Family Dollar Stores, Inc. 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.

Amendment and/or Termination of the PLAN

The PLAN SPONSOR expects this PLAN to be continued indefinitely, but the PLAN SPONSOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN SPONSOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN SPONSOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

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RECENT CHANGES

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

PRESCRIPTION DRUG Changes:

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

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

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

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

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

GETTING STARTED WITH BLUE OPTIONS

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

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the coinsurance maximum or the deductible.
Deductible	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under the PLAN. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or expenses for noncovered expenses. If DEPENDENTS are covered, you each have an individual deductible and your family has a combined family deductible. Amounts applied to your OUT-OF-NETWORK deductible are credited to your IN-NETWORK deductible. However, amounts applied to your IN-NETWORK deductible are not credited to your OUT-OF-NETWORK deductible.
Coinsurance	Your share of the costs of a covered health service, calculated as a percent of the ALLOWED AMOUNT for the service
Coinsurance maximum	The total amount of expenses you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100%. Coinsurance maximum does not include copayments, deductible, charges over ALLOWED AMOUNTS, and charges for noncovered services. Charges applied to your OUT-OF-NETWORK coinsurance are credited to your IN-NETWORK coinsurance maximum. However, charges applied to your IN-NETWORK coinsurance are not credited to your OUT-OF-NETWORK coinsurance maximum.
CERTIFICATION penalty	If PRIOR REVIEW is not requested and CERTIFICATION obtained for covered OUT-OF-NETWORK inpatient admissions, allowed charges will be reduced by 25%, then deductible and coinsurance will be applied.

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.

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in "Glossary" at the end of this benefit booklet.

Aviso Para AFILIADOS Que No Hablan Ingles

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

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 services which require PRIOR REVIEW and CERTIFICATION in order to avoid a partial or 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?"

WHOM DO I CONTACT?

Toll-Free Phone Numbers, Website and Addresses

BCBSNC Website: bcbsnc.com/members/familydollar	Find a network PROVIDER by location or specialty, get information about top-performing facilities, access PRESCRIPTION DRUG information, and information and news about BCBSNC.
Member Services Website: mybcbsnc.com	Use our secure website that reflects your specific benefits and information to verify benefits and eligibility, check claims status, download claim and other forms, manage your account, request new ID CARDS, get helpful wellness information and more.
BCBSNC Customer Service: 1-877-275-9787 8 a.m. - 9 p.m. Monday-Friday, except holidays	For questions regarding your benefits, claims inquiries, and new ID CARD requests or to voice a complaint.
PRIOR REVIEW and CERTIFICATION To request, MEMBERS call: 1-877-275-9787 PROVIDERS, call: 1-800-672-7897	Some services require PRIOR REVIEW and CERTIFICATION from BCBSNC before they are considered for coverage. The list of these services may change from time to time. Current information about which services require PRIOR REVIEW can be found online at bcbsnc.com/members/familydollar .
Magellan Behavioral Health: 1-800-359-2422	For mental health and substance abuse services, BCBSNC delegates the administration of these benefits to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact Magellan Behavioral Health directly and request PRIOR REVIEW for inpatient and certain outpatient services, except in EMERGENCIES. In the case of an EMERGENCY, please notify Magellan Behavioral Health as soon as possible.
Out of North Carolina Care 1-800-810-2583	For help in obtaining care outside of North Carolina or the U.S., call this number or visit bcbs.com .
HealthLine BlueSM 1-877-477-2424	To receive answers to your medical questions, support in managing your health, or coaching to meet lifestyle needs, specially trained nurses are available 24/7 to answer these questions and more.
BCBSNC Health Management Programs: 1-800-218-5295	For information about programs and support for managing specific health conditions, such as asthma, diabetes, heart disease, high blood pressure, and more.

WHOM DO I CONTACT? (cont.)

Toll-Free Phone Numbers, Website and Addresses (con't)

Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
PRESCRIPTION DRUG Claims Filing: Medco Health Solutions, Inc. PO Box 14711 Lexington, KY 40512	Mail completed PRESCRIPTION DRUG claims to this address for claims incurred on or before March 31, 2012.
PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: BCBSNC P.O. Box 14501 Lexington, KY 40512-4501	Mail completed PRESCRIPTION DRUG claims to this address for claims incurred beginning April 1, 2012.
COBRA Administrator CONEXIS 1-866-206-5751	For questions regarding your COBRA benefits, contact CONEXIS.
Add/Remove Someone From Your Policy 1-866-377-6420	Contact your Human Resources Contact Center online at www.MyFamilyDollarBenefits.com .

Blue Extrassm - Value-Added Programs

Not all plans have access to all Blue Extras programs. These programs are not covered benefits and are outside of the PLAN. To see if you are eligible for these programs, 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.

<p>Chiropractic Services 1-877-258-3334 8 a.m. - 9 p.m. Monday-Friday, except holidays</p>	<p>For information about discounts on chiropractic services and a practitioner directory, call or visit mybcbsnc.com.</p>
<p>Audio Bluesm 1-877-979-8000 (vendor network AHAA)</p>	<p>For information about discounts on hearing aids, call or visit mybcbsnc.com.</p>
<p>Blue Pointssm 1-888-705-7050 8 a.m. - 6 p.m. Monday-Friday, except holidays</p>	<p>For information about our physical activity and wellness incentive program, call or visit mybcbsnc.com.</p>
<p>Blue Pointssm for Teens 1-888-705-7050 8 a.m. - 6 p.m. Monday-Friday, except holidays</p>	<p>For information about our physical activity and wellness incentive program for teens ages 13-17, call or visit mybcbsnc.com.</p>
<p>Blue Pointssm for Kids 1-888-705-7050 8 a.m. - 6 p.m. Monday-Friday, except holidays</p>	<p>For information about our physical activity and wellness incentive program for teens ages 6-12, call or visit mybcbsnc.com.</p>
<p>Blue365TM 1-888-705-7050 8 a.m. - 6 p.m. Monday-Friday, except holidays</p>	<p>Health and wellness information support and services, and special member savings available 365 days a year.</p>
<p>Get Fit Bluesm</p>	<p>For information about nutrition and weight management discounts, visit mybcbsnc.com.</p>
<p>Optic Bluesm 1-888-763-8123 8 a.m. - 6 p.m. Monday-Friday, except holidays</p>	<p>For information about discounts on corrective laser eye surgery, call or visit mybcbsnc.com.</p>
<p>Vita Bluesm 1-888-234-4123 8 a.m. - 5 p.m. Monday-Friday, except holidays</p>	<p>For information about discounts on vitamins, minerals and herbal supplements, call or visit mybcbsnc.com.</p>

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options 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 part of the ALLOWED AMOUNT that the PLAN pays
- 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
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. **However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY And URGENT CARE 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 Blue Options network before receiving care. Find a PROVIDER on the BCBSNC website at bcbnsnc.com or call BCBSNC Customer Service at the number listed on your ID CARD or in "Whom Do I Contact?"

SUMMARY OF BENEFITS (cont.)

BENEFIT PERIOD - January 1, 2012 through December 31, 2012

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

Benefits	IN-NETWORK	OUT-OF-NETWORK
<p>PROVIDER'S Office</p>		
<p>See Outpatient Services for OUTPATIENT CLINIC or HOSPITAL-based services. OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined in- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p>		
<p>OFFICE VISIT Services</p>		
<p>PRIMARY CARE PROVIDER</p>	<p>\$30 copayment</p>	<p>50% after deductible</p>
<p>SPECIALIST</p>	<p>\$60 copayment</p>	<p>50% after deductible</p>
<p>This includes: office SURGERY, x-rays and lab tests.</p>		
<p>CT Scans, MRIs, MRAs and PET Scans</p>	<p>80% after deductible</p>	<p>50% after deductible</p>
<p>PREVENTIVE CARE Services</p>		
<p>This benefit is only for services that indicate a primary diagnosis of preventive or wellness. Also see "PREVENTIVE CARE" in "COVERED SERVICES." Please log on to the BCBSNC website at bcbsnc.com/preventive for the most up-to-date information on PREVENTIVE CARE under federal law.</p>		
<p>Screenings</p>	<p>100%</p>	<p>50% after deductible</p>
<p>This includes: gynecological exams, cervical cancer screening, ovarian cancer screening, mammograms (regardless of diagnosis), colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.</p>		
<p>Other PREVENTIVE CARE</p>	<p>100%</p>	<p>50% after deductible</p>
<p>This includes: routine physical exams, well baby, well-child care, and immunizations. See "COVERED SERVICES" for a list of PREVENTIVE CARE services.</p>		

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
Therapy Services		
SHORT-TERM REHABILITATIVE THERAPIES	\$60 copayment	50% after deductible
<p>Combined in- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings. 60 visits per BENEFIT PERIOD for physical/occupational therapy. 30 visits per BENEFIT PERIOD for chiropractic services. 30 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p>		
OTHER THERAPIES	80% after deductible	50% after deductible
<p>Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for OTHER THERAPIES provided in an outpatient setting.</p>		
INFERTILITY Services		
PRIMARY CARE PROVIDER	\$30 copayment	50% after deductible
SPECIALIST	\$60 copayment	50% after deductible
Routine Eye Exam	100%	Benefits not available
Lenses And Frames	\$100 per BENEFIT PERIOD	
<p>The PLAN will reimburse you up to the BENEFIT PERIOD MAXIMUM for prescribed eyeglasses and hard, soft or disposable contact lenses. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.</p>		
URGENT CARE Centers and Emergency Room		
URGENT CARE Centers	\$50 copayment	\$50 copayment
PREVENTIVE CARE services received in an URGENT CARE Center	100%	50% after deductible
<p>This benefit is only for services that indicate a primary diagnosis of preventive or wellness, and which are identified under federal law as being eligible. For a list of services, see "PREVENTIVE CARE" in "COVERED SERVICES."</p>		
Emergency Room Visit	\$150 copayment then 80% after deductible	\$150 copayment then 80% after deductible
<p>If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.</p>		

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	80% after deductible	50% after deductible
PREVENTIVE CARE Services	100%	50% after deductible
<p><u>This benefit is only for services that indicate a diagnosis of preventive or wellness.</u> For a list of services, see "PREVENTIVE CARE" in "COVERED SERVICES."</p>		
Outpatient		
Physician Services	80% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based Services	80% after deductible	50% after deductible
HOSPITAL-based or OUTPATIENT CLINIC Services	80% after deductible	50% after deductible
Therapy Services	80% after deductible	50% after deductible
<p>Includes SHORT-TERM REHABILITATIVE THERAPIES and OTHER THERAPIES including dialysis; see PROVIDER'S Office for visit maximums.</p>		
PREVENTIVE CARE Services	100%	50% after deductible
<p>This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of covered services, see "PREVENTIVE CARE" in "COVERED SERVICES." Benefits will differ if the claim for the PREVENTIVE CARE service indicates a diagnosis other than preventive/wellness.</p>		
Outpatient Diagnostic Services		
Outpatient lab tests and mammography, when performed alone (physician and HOSPITAL-based services)	100%	50% after deductible
Outpatient lab tests and mammography, when performed with another service		
Physician Services	100%	50% after deductible
HOSPITAL and HOSPITAL-based Services	80% after deductible	50% after deductible

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
Inpatient		
<p>Physician Services HOSPITAL and HOSPITAL-based Services</p> <p>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. If newborn is admitted, no additional per admission copayment is to be taken but an additional deductible will apply. Baby must be enrolled in health coverage in order for claims to be paid.</p>	<p>80% after deductible \$200 per admission copay, then 80% after deductible</p>	<p>50% after deductible \$200 per admission copay, then 50% after deductible</p>
SKILLED NURSING FACILITY		
<p>Combined in- and OUT-OF-NETWORK maximum of 60 days per BENEFIT PERIOD. Services applied to the deductible count towards this day maximum. Any services in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.</p>	<p>80% after deductible</p>	<p>50% after deductible</p>
Other Services		
<p>Includes DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, and home health care. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to a LIFETIME MAXIMUM of \$600. When covered, benefits for hearing aids are limited to \$2,500 per hearing impaired ear every 36 months. Home health care is limited to a combined in- and OUT-OF-NETWORK maximum of 40 days per BENEFIT PERIOD, and home health care visits applied to the deductible count towards this day maximum. Any services in excess of these BENEFIT PERIOD or LIFETIME MAXIMUMS are not COVERED SERVICES.</p>	<p>80% after deductible</p>	<p>50% after deductible</p>
<p>Ambulance Services</p>	<p>80% after deductible</p>	<p>80% after deductible</p>

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
Mental Health And Substance Abuse Services		
Mental Health Office Services	\$60 copayment	50% after deductible
Mental Health Inpatient Services Physician Services HOSPITAL and HOSPITAL -based Services	80% after deductible \$200 per admission copay, then 80% after deductible	50% after deductible \$200 per admission copay, then 50% after deductible
Mental Health Outpatient Services Physician Services HOSPITAL and HOSPITAL-based Services	80% after deductible 80% after deductible	50% after deductible 50% after deductible
Substance Abuse Office Services	\$60 copayment	50% after deductible
Substance Abuse Inpatient Services Physician Services HOSPITAL and HOSPITAL-based Services	80% after deductible \$200 per admission copay, then 80% after deductible	50% after deductible \$200 per admission copay, then 50% after deductible
Substance Abuse Outpatient Services Physician Services HOSPITAL and HOSPITAL-based Services	80% after deductible 80% after deductible	50% after deductible 50% after deductible

SUMMARY OF BENEFITS *(cont.)*

Benefits	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM, Deductible, and Coinsurance Maximum		
The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.		
LIFETIME MAXIMUM Unlimited for all services, except orthotic devices for POSITIONAL PLAGIOCEPHALY and INFERTILITY drugs. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.	Unlimited	Unlimited
Deductible Individual, per BENEFIT PERIOD Family, per BENEFIT PERIOD Charges for the following do not apply to the BENEFIT PERIOD deductible: <ul style="list-style-type: none"> • inpatient newborn care for well baby • PRESCRIPTION DRUGS. 	\$1,500 \$3,000	\$3,000 \$6,000
Coinsurance Maximum Individual, per BENEFIT PERIOD Family, per BENEFIT PERIOD Charges for the following do not apply to the BENEFIT PERIOD coinsurance maximum: <ul style="list-style-type: none"> • PRESCRIPTION DRUGS. 	\$5,000 \$10,000	\$10,000 \$20,000
CERTIFICATION Requirements		
<p>Certain services, regardless of the location, require PRIOR REVIEW and CERTIFICATION by BCBSNC in order to receive benefits. If you go to an IN-NETWORK PROVIDER in North Carolina, your PROVIDER will request PRIOR REVIEW when necessary. If you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any PROVIDER outside of North Carolina, you are responsible for requesting or ensuring that your PROVIDER requests PRIOR REVIEW by BCBSNC. Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced by 25% or a full denial of benefits. See "COVERED SERVICES" and "Prospective Review/PRIOR REVIEW" in "UTILIZATION MANAGEMENT."</p> <p>The PLAN delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. PRIOR REVIEW and CERTIFICATION by Magellan Behavioral Health are required for inpatient and certain outpatient mental health and substance abuse services received from an IN-NETWORK PROVIDER, except for EMERGENCIES. Please see the number in "Whom Do I Contact?"</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS		
(% represents member coinsurance)		
GENERIC Drugs Tier 1	20% (min. \$4, max. \$30)	20% (min. \$4, max. \$30)
BRAND NAME Drugs s Tier 2	30% (min. \$20, max. \$50)	30% (min. \$20, max. \$50)
Non-preferred BRAND NAME Drugs or Preferred SPECIALTY DRUGS Tier 3	40% (min. \$40, max. \$75)	40% (min. \$40, max. \$75)
SPECIALTY DRUGS Tier 4 Diabetic Supplies, Spacers and Peak Flow Meter	40% (min. \$40, max. \$75) 25%	40% (min. \$40, max. \$75) 25%
<p>For each 30-day supply you will pay the applicable minimum, but not more than the applicable maximum. Any OUT-OF-NETWORK charges over the ALLOWED AMOUNT are not included in this maximum. INFERTILITY drugs are limited to a combined in- and OUT-OF-NETWORK LIFETIME MAXIMUM of \$2,500 per MEMBER. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.</p>		
Mail Order supply		
GENERIC Drugs Tier 1	20% (min. \$10, max. \$75) for 90 day supply of maintenance medication	
BRAND NAME Drugs s Tier 2	30% (min. \$50, max. \$125) for 90 day supply of maintenance medication	
Non-preferred BRAND NAME Drugs or Preferred SPECIALTY DRUGS Tier 3	40% (min. \$100, max. \$187.50) for 90 day supply of maintenance medication	
SPECIALTY DRUGS Tier 4	40% (min. \$100, max. \$187.50) for 90 day supply of maintenance medication	
<p>For each 30-day supply you will pay the applicable minimum, but not more than the applicable maximum.</p>		

HOW BLUE OPTIONS WORKS

As a MEMBER of the Blue Options plan, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options network - the main difference will be the cost to you. Benefits are available for services from an IN-or OUT-OF-NETWORK PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS, please visit the BCBSNC website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" Here's a look at how it works:

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	<p>IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the BlueCard[®] program. IN-NETWORK PROVIDERS agree to limit charges for COVERED SERVICES to the ALLOWED AMOUNT.</p> <p>The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on the BCBSNC website at bcbsnc.com, or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"</p>	<p>OUT-OF-NETWORK PROVIDERS are not designated as a Blue Options PROVIDER by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."</p>
ALLOWED AMOUNT vs. Billed Amount	<p>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 non-covered expenses.</p>	<p>You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, non-covered expenses and CERTIFICATION penalty amounts, if any.</p>
Referrals	<p>You are not required to obtain any referrals.</p>	<p>You are not required to obtain any referrals.</p>
After-hours Care	<p>If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.</p>	
Care Outside of North Carolina	<p>Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard program, and benefits are provided at the IN-NETWORK benefit level.</p>	<p>If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."</p>

	IN-NETWORK	OUT-OF-NETWORK
PRIOR REVIEW	<p>IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. If you receive services outside of North Carolina (even if you see an IN-NETWORK PROVIDER), you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC.</p> <p>For inpatient or certain outpatient mental health and substance abuse services, either in or outside of North Carolina, contact Magellan Behavioral Health to request PRIOR REVIEW and receive CERTIFICATION.</p> <p>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.</p>	<p>You are responsible for requesting or ensuring that your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by BCBSNC. Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.</p>
Filing Claims	<p>IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC.</p>	<p>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.</p>

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.

For more information, see one of the following sections: "EMERGENCY Care," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC's access to care standards, see the BCBSNC website at bcbsnc.com and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Blue Options 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 the BCBSNC website at **mybcbnsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?"

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

It is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care 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 the BCBSNC 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.

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

COVERED SERVICES

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

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

Office Services

Care you receive as part of an OFFICE VISIT, electronic visit, or house call is covered, except as otherwise noted in this benefit booklet. Some PROVIDERS may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

A copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

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

The PROVIDER search on the BCBSNC website at **bcbnsnc.com** indicates which PROVIDERS will collect deductible and coinsurance, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for this information.

Office Services Exclusion



- Certain self-injectable PRESCRIPTION DRUGS that can be self-administered. The list of these drugs may change from time to time. See the BCBSNC website at **bcbnsnc.com** or call BCBSNC Customer Service for a list of these drugs excluded in the office.



Also see "PRESCRIPTION DRUG Benefits" for information about purchasing self injectable PRESCRIPTION DRUGS at a pharmacy.

PREVENTIVE CARE

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. Otherwise, services will be subject to your IN-NETWORK benefit level for the location where services are received. In addition, the PLAN may use reasonable medical management procedures to determine any coverage limitations.

COVERED SERVICES *(cont.)*

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

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

PREVENTIVE CARE COVERED SERVICES include:

Nutritional Counseling

The PLAN covers nutritional counseling visits, which may include counseling specific to achieving or maintaining a healthy weight.

Routine Physical Examinations and Screenings

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

Well-Baby and Well-Child Care

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

Immunizations

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

Immunizations Exclusion



- Immunizations required for occupational hazard or international travel, unless specifically covered by the PLAN.

Routine Eye Exams

This benefit is only available IN-NETWORK.

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.

Routine Eye Exams Exclusions



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

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.

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.

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

- has a family history with at least one first-degree relative with ovarian cancer, and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- tested positive for a hereditary ovarian cancer syndrome.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per BENEFIT PERIOD. 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 calendar year, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

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

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your DOCTOR find the cause and extent of your condition in order to plan for your care. Multiple radiology or imaging procedures on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

COVERED SERVICES (cont.)



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

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

Emergency Care

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

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

URGENT CARE

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.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. However, maternity benefits for DEPENDENT CHILDREN cover only treatment for COMPLICATIONS OF PREGNANCY. 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 pre-natal services depending upon how the services are billed by the PROVIDER.

COVERED SERVICES (cont.)

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Deductible and coinsurance apply for the remainder of maternity care benefits.
Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see PREVENTIVE CARE in "Summary of Benefits.")	For first 48/96 hours, only one admission copayment or BENEFIT PERIOD deductible is required for both mother and baby.
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy. In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours.	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required in order to avoid a penalty.	The baby must meet the individual BENEFIT PERIOD deductible if applicable. 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 charges are subject to the BENEFIT PERIOD deductible if the newborn is added and covered under the policy.

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a

COVERED SERVICES *(cont.)*

shorter stay if the attending PROVIDER (e.g., your DOCTOR, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

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



See "Summary of Benefits" for limitations that may apply. For information about coverage of PRESCRIPTION DRUGS for INFERTILITY, see "PRESCRIPTION DRUG Benefits."

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 includes female tubal occlusion and male vasectomy.

Contraceptive Devices

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



See "PRESCRIPTION DRUG Benefits" for coverage of oral contraceptives.



Family Planning Exclusions

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

FACILITY SERVICES

Benefits are provided for:

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

COVERED SERVICES (cont.)

- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the Blue Options network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. Take home drugs are covered as part of your PRESCRIPTION DRUG benefit.
- Ⓒ PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and EMERGENCIES. See "Maternity Care," if applicable, and "EMERGENCY Care."
- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined in- and OUT-OF-NETWORK day maximum per BENEFIT PERIOD.
- Ⓒ PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC to avoid a penalty. See "Summary of Benefits."

Other Services

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.

The PLAN covers services in an air ambulance traveling from the site of an EMERGENCY to a HOSPITAL when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land.

- Ⓒ Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

! Ambulance Service Exclusion

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

Blood

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.

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a

life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the 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

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

Dental Treatment Covered Under Your Medical Benefit

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

In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a HOSPITAL or AMBULATORY SURGICAL CENTER. This benefit is only available to DEPENDENT CHILDREN below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other DENTAL SERVICES, including the charge for SURGERY, are not covered unless specifically covered by 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.

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:


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

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

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


Diabetes-Related Services

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

 See "Summary of Benefits," depending on where services are received.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a DOCTOR. Equipment may be purchased or rented at the discretion of 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 now provides coverage for MEDICALLY NECESSARY hearing aids and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER'S needs. This benefit is limited to once every 36 months. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN), and/or other skilled care services like SHORT-TERM REHABILITATIVE THERAPIES. These services are covered by the PLAN when MEDICALLY NECESSARY and when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. 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.



See "Summary of Benefits" for home health day limits.



Home Health Care Exclusions

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

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of **PRESCRIPTION DRUGS** directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a **DOCTOR**. These services must be provided under the supervision of an **RN** or **LPN**.



PRIOR REVIEW and **CERTIFICATION** are required for certain home infusion therapy services or services will not be covered.

HOSPICE Services

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



HOSPICE Services Exclusion

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

Lymphedema-Related Services

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. 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 the **BCBSNC** website at **bcbnsnc.com** or call **BCBSNC** Customer Service.



MEDICAL SUPPLIES Exclusion

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

Orthotic Devices

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



Orthotic Devices Exclusions

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

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 is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a **HOME HEALTH AGENCY**.



See "Care Management."



Private duty nursing requires **PRIOR REVIEW** and **CERTIFICATION** or services will not be covered.



Private Duty Nursing Exclusion

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

PROSTHETIC APPLIANCES

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**.



For subsequent lens replacement, see "Lenses and Frames."



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



PROSTHETIC APPLIANCES Exclusions

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

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. Surgical benefits include diagnostic **SURGERY**, such as biopsies, and reconstructive **SURGERY** performed to correct **CONGENITAL** defects that result in functional impairment of newborn, adoptive, and **FOSTER CHILDREN**.



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



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

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

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending DOCTOR and administered by or under the supervision of a DOCTOR other than the attending surgeon or assistant at SURGERY.



Benefits are not available for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, 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
- Prosthesis and physical complications of all stages of the mastectomy, including lymphedemas.



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

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

The benefits described above are subject to the same applicable deductibles, copayment or coinsurance and limitations as applied to other medical and surgical benefits provided under the PLAN.

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



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



Temporomandibular Joint (TMJ) Services Exclusions

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

Therapies

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

SHORT-TERM REHABILITATIVE THERAPIES

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

- Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation) 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). SHORT-TERM REHABILITATIVE THERAPY received while an inpatient is not included in the BENEFIT PERIOD MAXIMUM.

Benefits may vary depending on where services are received. See "Summary of Benefits" for additional information and any visit maximums.


OTHER THERAPIES

The PLAN covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy).

 Breast brachytherapy is INVESTIGATIONAL but will be covered upon PRIOR REVIEW and CERTIFICATION, based on meeting the American Society of Breast Surgeons (ASBS) criteria.

- Chemotherapy, including intravenous chemotherapy.

 Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants." Also see "PRESCRIPTION DRUG Benefits" regarding related covered PRESCRIPTION DRUGS.

Therapy Exclusions

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

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 based on BCBSNC guidelines that are available upon request from a transplant coordinator.

Travel and lodging is covered for recipient only when rendered at a Blue Distinction Center. No coverage for donor. \$10,000 limit for travel and lodging.

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

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

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of \$10,000 per transplant.
- 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.

Mental Health and Substance Abuse Services

The PLAN provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or OTHER PROVIDER.



Coverage for IN-NETWORK inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. BCBSNC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. To understand more about when you need to contact Magellan Behavioral Health, see "How to Access Mental Health and Substance Abuse Services."

OFFICE VISIT Services

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

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

Outpatient Services

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

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

Certain outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. Visit the BCBSNC website at mybcbsnc.com or call Magellan Behavioral Health for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

Inpatient Services

Covered inpatient treatment services also include:

- Each service listed in this section under OFFICE VISIT services
- Semi-private room and board

- Detoxification to treat substance abuse.

How to Access Mental Health and Substance Abuse Services

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

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



Mental Health and Substance Abuse Services Exclusions and Limitations

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

PRESCRIPTION DRUG Benefits

Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including self-administered injectable medications, and contraceptive drugs and devices
- Certain 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
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to treatment of INFERTILITY and SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for 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."

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

Situation	Value
Where you get your PRESCRIPTION filled	<p>Your cost will be less if you use an IN-NETWORK pharmacy in North Carolina - or outside the state and show your ID Card. (Unless otherwise specified under this PLAN, you may receive your PRESCRIPTION DRUGS and diabetic supplies from any pharmacy.) You may also get your PRESCRIPTION filled by an OUT-OF-network pharmacy; however, you may be asked to pay the full cost of the PRESCRIPTION DRUG and file a claim. You will be reimbursed the ALLOWED AMOUNT less any applicable deductible, coinsurance or copayment. Any charges over the ALLOWED AMOUNT are your responsibility.</p> <p>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 "Whom Do I Contact?" so that the claim will be processed at the IN-NETWORK level.</p>

COVERED SERVICES *(cont.)*

<p>How the type of PRESCRIPTION DRUG may determine the amount you pay</p>	<p>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. For example, GENERIC PRESCRIPTION DRUGS are on Tier 1 and will be less expensive than PRESCRIPTION DRUGS on another tier. The PRESCRIPTION DRUGS listed in the FORMULARY or their tier placement may change from time to time.</p>
<p>How your PRESCRIPTION is dispensed</p>	<p>You can save valuable time by getting up to a 90-day supply of PRESCRIPTION DRUGS you take on a regular basis through mail-order service, if your DOCTOR writes a new PRESCRIPTION for up to 90 days. Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. If this applies to your particular PRESCRIPTION and these drugs are subject to a copayment, you will pay either two to three copayments depending on the quantity you receive.</p> <p>You cannot refill a PRESCRIPTION until:</p> <ul style="list-style-type: none">• 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, <p>except during a government-declared state of emergency or disaster in the county in which you reside. During these circumstances, you must request a refill within 29 days after the date of the emergency or disaster (not the date of the declaration). A refill of a PRESCRIPTION with quantity limitations may take into account the proportionate dosage use prior to the disaster.</p>

COVERED SERVICES *(cont.)*

Use of GENERIC PRESCRIPTION DRUGS	When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG, such as a GENERIC, could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND NAME PRESCRIPTION DRUG, your cost will be higher.
PRIOR REVIEW Requirements	PRIOR REVIEW and CERTIFICATION by BCBSNC are required for some PRESCRIPTION DRUGS to be covered. BCBSNC may change the list of these PRESCRIPTION DRUGS from time to time.
SPECIALTY DRUGS	BCBSNC has a separate pharmacy network for purchasing select SPECIALTY DRUGS ("Specialty Network"). These SPECIALTY DRUGS (which include specialty GENERIC or BRAND-NAME PRESCRIPTION DRUGS, as well as BIOLOGIC or BIOSIMILAR PRESCRIPTION DRUGS) must be dispensed by a pharmacy participating in the Specialty Network in order to receive IN-NETWORK benefits. These drugs are limited to a 30-day supply.
Restricted-Access Drugs and Devices	For certain PRESCRIPTION DRUGS to be covered, BCBSNC requires that the MEMBER has tried a preferred drug or device. Coverage for these restricted-access drugs and devices may be provided without the use of a preferred drug or device if the PROVIDER certifies in writing that the MEMBER has tried the more affordable, preferred drug or device first, and it was ineffective in treating the same condition and, in the opinion of the PROVIDER, is likely to be detrimental to the MEMBER'S health or ineffective in treating the condition in the future. If you meet the above criteria, your PROVIDER can request that you continue to be prescribed a restricted-access drug or device.
Quantity Limitations	BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by BCBSNC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.

Benefit Limitations	<p>Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include</p> <ul style="list-style-type: none"> - the amount dispensed per PRESCRIPTION, per day or per defined time period; - per lifetime; per month's supply; - or the amount dispensed per single copayment, if applicable. <p>Note: Excess quantities are not covered.</p>
Where to find more information	<p>You may visit the BCBSNC website at bcbssc.com or call BCBSNC Customer Service at the number listed in "Whom Do I Contact?" for the following:</p> <ul style="list-style-type: none"> • List of IN-NETWORK pharmacies (including the Specialty Network), note this list may change from time to time • List of PRESCRIPTION DRUGS that: <ul style="list-style-type: none"> _ require PRIOR REVIEW and CERTIFICATION _ are restricted-access drugs and devices _ are subject to benefit limitations _ are subject to quantity limitations _ must be dispensed through the Specialty Network in order to receive IN-NETWORK benefits • Any special programs that may apply • A copy of the FORMULARY



PRESCRIPTION DRUG Benefits Exclusions

Any PRESCRIPTION DRUG that is:

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

And any other drug that is:

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

Lenses and Frames

The PLAN provides reimbursement for COVERED SERVICES for routine vision correction including eyeglass frames and prescribed lenses for single vision, bifocal or trifocal and hard, soft or disposable contact lenses. This does not include any service covered as a PROSTHETIC APPLIANCE.



Benefits are limited to a dollar amount per BENEFIT PERIOD. See "Summary of Benefits."

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

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 MEMBER, 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

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, 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

WHAT IS NOT COVERED? (cont.)

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 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 specifically covered by the PLAN

The following **drugs**:

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

E

Ear piercing

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

The following **equipment**:

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

WHAT IS NOT COVERED? (cont.)

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

H

Routine **hearing** examinations and **hearing aids** or examinations for the fitting of hearing aids except as specifically covered by the PLAN

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

Hypnosis except when used for control of acute or chronic pain

I

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

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

L

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

M

Services or supplies deemed not **MEDICALLY NECESSARY**

N

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

O

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

P

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

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

R

The following **residential care** services:

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

WHAT IS NOT COVERED? (cont.)

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

S

Services or **supplies** that are:

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

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

SEXUAL DYSFUNCTION unrelated to organic disease

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

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

T

The following types of **therapy**:

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

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except as specifically covered by the PLAN

V

The following **vision** services:

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

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for PRESCRIPTION prenatal vitamins or PRESCRIPTION vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your preventive care benefits for certain individuals

W

Wigs, hair pieces and hair implants for any reason.

WHEN COVERAGE BEGINS AND ENDS

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.

Team Member Position	Benefit Waiting Period
CORPORATE Executives, Directors, Pilots, Assistant General Counsel	Immediate
DISTRIBUTION CENTER Management	
STORE District Managers	
CORPORATE Exempt and NonExempt	1 month
DISTRIBUTION CENTER Exempt and NonExempt	
STORE Managers, Assistant Managers, Manager Trainees	
STORE Clerks and Remodel Staff	3 months

For DEPENDENTS to be covered under the PLAN, you must be covered and your DEPENDENT must be one of the following:

- Your spouse, under a legally valid, existing marriage between persons of the opposite sex
- Your same sex domestic partner, so long as you and your same sex domestic partner have attested to the PLAN ADMINISTRATOR, in writing, using the domestic partner affidavit, to the following:
 1. That you and your same sex domestic partner are both mentally competent
 2. That you and your same sex domestic partner are both at least the age of consent for marriage in the state where you are a resident
 3. That you and your same sex domestic partner are not related by blood to a degree of closeness that would prohibit legal marriage in the state where you are a resident
 4. That you and your same sex domestic partner are not married to anyone else
 5. That you and your same sex domestic partner are mutually responsible for the cost of basic living expenses as evidenced by joint home ownership, common investments, or some other similar evidence of financial interdependence
 6. That you and your same sex domestic partner live together and intend to do so permanently
 7. That you do not currently have a domestic partner covered under the PLAN
 8. That you have not had a domestic partner covered under the PLAN at any time within the past 12 months before adding this domestic partner unless the previous domestic partnership was terminated by death.

The conditions listed in 2-8 above must remain true and correct for your same sex domestic partner to remain an eligible DEPENDENT under the terms of this coverage.

Your employer requires proof that your dependent spouse meets the above requirement.

- Your, your spouse's or your same sex domestic partner's DEPENDENT CHILDREN, under the age of 26, including new born children, stepchildren, adoptive children from date of placement for adoption, children for whom health benefit coverage is required under a court or administrative order, and for children for whom you have legal guardianship to their 26th birthday. Your EMPLOYER requires proof that your DEPENDENT CHILD meets the definition of DEPENDENT CHILD as outlined in the "Glossary." For grandfathered plans, adult children (age 18 and older) who are eligible to enroll as a covered employee or dependent under an employer-sponsored health plan may not be eligible to enroll under this PLAN.
- A DEPENDENT CHILD who is either mentally retarded 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 age of 26. 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 that you elect coverage and/or add DEPENDENTS when first eligible or when you experience a qualified change in status you should contact the Human Resources Contact Center within 31 days of the

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

event. When you elect coverage will determine whether you and your DEPENDENTS are timely or late enrollees and the length of any waiting period for PRE-EXISTING CONDITIONS.

WAITING PERIODS for PRE-EXISTING CONDITIONS

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



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



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

Benefits will not be provided for any condition excluded from coverage by the terms of the PLAN, even after the expiration of the WAITING PERIODS stated above.

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

Timely Enrollees

Timely enrollees are subject to a 12-month WAITING PERIOD for PRE-EXISTING CONDITIONS. MEMBERS under age 19 are not subject to a PRE-EXISTING WAITING PERIOD.

You are a timely enrollee if you apply for coverage and/or add DEPENDENTS within a 31-day period following any of the qualifying events listed below unless otherwise noted. Coverage is effective the 1st day of the pay period following a completed request for enrollment.

The following are considered qualifying events:

- You or your DEPENDENTS become eligible for coverage under the PLAN
- You get married or obtain a DEPENDENT through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
 - you and/or your DEPENDENTS are otherwise eligible for coverage under 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, legal separation, divorce, loss of DEPENDENT status, death of the MEMBER, 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 Children's Health Insurance Program (CHIP) and apply for coverage under this PLAN within 60 days.

Reminder: You may make mid-year changes to your medical elections only if you experience a qualifying change in status. Requests must be received by the Human Resources Contact Center within 31 days of the qualifying change in status.

Late Enrollees

If you are applying for coverage at a time which does not qualify you or your DEPENDENTS as timely enrollees as stated above, then you are considered late enrollees. Late enrollees are subject to a(n) 12-month WAITING PERIOD for PRE-EXISTING CONDITIONS. MEMBERS under age 19 are not subject to a WAITING PERIOD.



See also “Adding or Removing a DEPENDENT.”

Adding or Removing a DEPENDENT

Do you want to add or remove a DEPENDENT? You must notify the Human Resources Contact Center within 31 days of the qualifying event.

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. You must notify the Human Resources Contact Center within 31 days of the qualifying event.

DEPENDENTS may be removed from coverage by contacting the Human Resources Contact Center. 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 legal separation, divorce or death. Failure to timely notify your Human Resources Contact Center 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 Human Resources Contact Center.

Types of Coverage

These are the types of coverage available:

- Employee-only coverage - The PLAN covers only you
- Employee-spouse coverage - The PLAN covers you and your spouse or same sex domestic partner
- Employee-children coverage - The PLAN covers you and your DEPENDENT CHILDREN
- Family coverage - The PLAN covers you, your spouse or same sex domestic partner and your DEPENDENT CHILDREN.

Reporting Changes

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact the Human Resources Contact Center. 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.

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 Human Resources Contact Center, who will discuss your option to continue 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 or legal separation
- 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.

Please note that Federal law defines marriage as the legal union between a man and a woman, so same sex domestic partners and children of the same sex domestic partner are not eligible for COBRA benefits. All references to DEPENDENTS in this section do not apply to a same sex domestic partner or their children.

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 COBRA 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 COBRA 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 Human Resources Contact Center within 31 days of the following qualifying events:

- Divorce
- Legal separation
- 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.

WHEN COVERAGE BEGINS AND ENDS (cont.)

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

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

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

If you are covered by the PLAN and called to the uniformed services, as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA), consult the Human Resources Contact Center. The Human Resources Contact Center will advise you about the continuation of coverage and reinstatement of coverage under this PLAN as 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

BCBSNC has been designated by the PLAN ADMINISTRATOR to 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. It may help you receive credit toward any new PRE-EXISTING CONDITIONS WAITING PERIOD that applies on subsequent coverage. You may request a Certificate of Creditable Coverage from BCBSNC Customer Service while you are still covered under the PLAN and up to 24 months following your termination.

You may call BCBSNC Customer Service at 1-877-275-9787 (toll-free), Monday through Friday 8:00 a.m. - 9:00 p.m. except holidays or visit the BCBSNC website at mybcbsnc.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 to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see "What if

WHEN COVERAGE BEGINS AND ENDS *(cont.)*

You Disagree With 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.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under the PLAN 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 (including your voluntary termination of coverage) or nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

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

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

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

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

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

PRIOR REVIEW (Pre-Service)

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

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

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

Urgent PRIOR REVIEW

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

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

Concurrent Reviews

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

If a request for an extension of treatment is urgent, the decision will be communicated to the requesting HOSPITAL or other facility as soon as possible, but no later than 24 hours after we receive the request. If BCBSNC needs more information to process your urgent review, BCBSNC will notify the requesting HOSPITAL or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for the requesting HOSPITAL or other facility to provide the information, whichever is earlier, BCBSNC will make a decision on the request within a reasonable time but no later than 48 hours.

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

In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you, your HOSPITAL'S or other facility's UM department and your PROVIDER. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Retrospective Reviews (Post-Service)

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



Care management (or case management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and 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 provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

Continuity of Care



Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for 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 Blue Options 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:

- in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the MEMBER'S life expectancy is six months or less.

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

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

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

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

Delegated UTILIZATION MANAGEMENT

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

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow 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,

UTILIZATION MANAGEMENT *(cont.)*

regulations, recommendations, and requirements. BCBSNC then seeks additional input from PROVIDERS who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

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

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

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

Any request for review should include:

- 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 the BCBSNC website at mybcbsnc.com or call BCBSNC Customer Service at the number given in "Whom Do I Contact?"

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

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

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

Quality of Care Complaints

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

First Level Appeal

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

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be evaluated by a licensed medical DOCTOR who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

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

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

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

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

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

Notice of Decision

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

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

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by contacting BCBSNC Customer Service or by calling the number given in "Whom Do I Contact?" An expedited review will take place in

WHAT IF YOU DISAGREE WITH A DECISION? (cont.)

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, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

Correspondence related to a request for a review through the PLAN'S appeals process should be sent to:
BCBSNC
Customer Service
PO Box 2291
Durham, NC 27702-2291

Final Review

After the second level appeal review is completed, you may request review of the appeal by the PLAN ADMINISTRATOR for a final decision.

External Review

Federal law provides for an external review of certain ADVERSE BENEFIT DETERMINATIONS by an external, independent review organization (IRO). This service is administered by the PLAN at no charge to you. The PLAN will notify you of your right to request an external review each time you receive:

- an ADVERSE BENEFIT DETERMINATION
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION, or
- a final internal ADVERSE BENEFIT DETERMINATION

In order to request an external review, BCBSNC must receive your request within four (4) months after the date of receipt of a notice of an ADVERSE BENEFIT DETERMINATION or final internal ADVERSE BENEFIT DETERMINATION. You are not eligible to request an external review until the internal appeals process has been completed and a final ADVERSE BENEFIT DETERMINATION has been issued by the PLAN. You have exhausted the PLAN'S internal appeal process once you have gone through the first level appeal process. While a second level appeal process is available to you, the process is completely voluntary and not required prior to requesting an external review. To request an external appeal, send your request to the following:

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

Expedited External Review - An expedited external review may be available if (1) the time required to complete either an expedited internal appeals review or a standard external review would reasonably be expected to jeopardize your life or health or ability to regain maximum function, or (2) the final internal ADVERSE BENEFIT DETERMINATION concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility. If your request is not accepted for expedited review, the PLAN may: (1) accept the case for standard external review if the internal appeals process has been exhausted; or (2) require the completion of the internal appeals process and another request for an external review.

Within five (5) business days of (or, for an expedited review, immediately upon) receiving your request for an external review, the PLAN must determine whether the external review is eligible ("preliminary review"). The request is eligible if it meets the following requirements:

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

- Your request is about a NONCERTIFICATION or a rescission of coverage
- You are or were covered under the PLAN at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the PLAN at the time the health care item or service was provided;
- The ADVERSE BENEFIT DETERMINATION or the final ADVERSE BENEFIT DETERMINATION does not relate to your failure to meet the requirements for eligibility under the terms of the PLAN (e.g., worker classification or similar determination);
- You have exhausted the PLAN'S internal appeal process unless you are not required to exhaust the internal appeals process; and
- You provided all the information and forms required to process an external review.

Within one (1) business day of (or, for expedited review, immediately upon) completing the preliminary review, the PLAN will notify you in writing of whether your request is complete and whether it has been accepted. If the PLAN notifies you that the request is incomplete, you must provide all requested information to the PLAN within the four (4) month filing period or within 48 hours following the receipt of the notice, whichever is later.

If the PLAN accepts your request, the assigned IRO will timely notify you in writing of the acceptance of the external review. The notice will include a notification that you may submit additional written information and supporting documentation relevant to the ADVERSE BENEFIT DETERMINATION to the assigned IRO within ten (10) business days following the date of receipt of the notice. Within five (5) business days (for an expedited review, as expeditiously as possible) after the date of assignment of the IRO, the PLAN shall provide the IRO the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION.

The IRO will send you and the PLAN written notice of its decision within 45 days. If the request is expedited, the IRO will notify you and PLAN as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request. If the notice is not in writing, the IRO shall provide written confirmation to you and the PLAN within 48 hours after the date of providing the notice. If the IRO'S decision is to reverse the ADVERSE BENEFIT DETERMINATION, the PLAN will immediately provide coverage or payment for the requested services or supplies. If you are no longer covered by the PLAN at the time the PLAN receives notice of the IRO'S decision to reverse the ADVERSE BENEFIT DETERMINATION, the PLAN will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been denied when first requested.

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

Delegated Appeals

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

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

Second level appeal is provided by BCBSNC.

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to which MEMBERS are Entitled

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

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 coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER'S future claims payment. 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 (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

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

BCBSNC's Disclosure of Protected Health Information (PHI)

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

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options 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 ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as " Inter-Plan Programs". As a MEMBER of 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

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

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

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

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

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

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

If you receive COVERED SERVICES from a 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.

Right of Recovery Provision

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.

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.

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.

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.

ADDITIONAL TERMS OF YOUR COVERAGE (cont.)

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.

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 potential 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 will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the PLAN is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER.

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. The PLAN is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

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 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 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.

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.

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.

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:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

- 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 "What if You Disagree with a Decision?" for more information.

Limitation of Actions

Since the PLAN is subject to ERISA, you must only exhaust the first level appeal process following the Notice of Claim requirement.



Please see "What if You Disagree with a Decision?" for details regarding the appeals process.

No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level appeal review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, the PLAN may coordinate benefits with the other plan.



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

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. 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.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

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

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

Note: 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.

BCBSNC 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 are coordinated with other group health plans, benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.

SPECIAL PROGRAMS

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:

- 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's website
- 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 may stop or change these programs at any time.

Health Information Services

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

GLOSSARY

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 Care", for PROVIDERS that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by BCBSNC that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where BCBSNC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or a charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY SURGICAL CENTER

A NONHOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:

- a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
- b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
- c) Does not provide inpatient accommodations
- d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

BENEFIT PERIOD

The period of time, as stated in the "Summary of Benefits," 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.

BIOLOGIC

A drug produced from proteins, living organisms or complex large molecule drugs.

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. BCBSNC makes the final determination of the classification of brand-name drug products based on information provided by the manufacturer and other external classification sources.

CERTIFICATION

The determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy 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 under age 26 who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse or same sex domestic partner for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to EMPLOYEE and/or spouse or same sex domestic partner, or 3) a child for whom the EMPLOYEE and/or spouse or same sex domestic partner has been court-ordered to provide coverage. The spouse or children of a dependent child are not considered DEPENDENTS.

DEVELOPMENTAL DYSFUNCTION

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

DOCTOR

Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or SURGERY by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a

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

DURABLE MEDICAL EQUIPMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

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

EMERGENCY SERVICES

Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition until the condition is STABILIZED, including pre-hospital care and ancillary services routinely available in the EMERGENCY department.

EMPLOYEE

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

EMPLOYER

Family Dollar Stores, Inc.

ERISA

The Employee Retirement Income Security Act of 1974.

EXPERIMENTAL

See INVESTIGATIONAL.

FACILITY SERVICES

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

FORMULARY

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

FOSTER CHILD(REN)

Children under age 18 i) for whom a guardian has been appointed by 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 that BCBSNC identifies as a generic. The classification of a PRESCRIPTION DRUG as a generic is determined by BCBSNC based on commercially available data resources.

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

IN-NETWORK

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

IN-NETWORK PROVIDER

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

INVESTIGATIONAL (EXPERIMENTAL)

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

- a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the 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)

GLOSSARY (cont.)

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

LIFETIME MAXIMUM

The maximum amount of 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.

MAINTENANCE THERAPY

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

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

- a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under 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, a mental condition, other than mental retardation alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-IV"). Mental illness does not include substance-related disorders, SEXUAL DYSFUNCTIONS not due to organic disease, and disorders coded as "V" codes in the DSM-IV.

NONCERTIFICATION

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

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

OTHER PROFESSIONAL PROVIDER

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

OTHER PROVIDER

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

OTHER THERAPY(IES)

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

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

OUT-OF-NETWORK

Not designated as participating in the Blue Options 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 PROVIDER by BCBSNC.

OUTPATIENT CLINIC(S)

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

PLAN

The EMPLOYER health benefit plan established by Family Dollar Stores, Inc. to provide health benefits for participants.

PLAN ADMINISTRATOR

Health & Welfare Administrative Committee

PLAN SPONSOR

Family Dollar Stores, Inc.

POSITIONAL PLAGIOCEPHALY

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

PRE-EXISTING CONDITION

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

PRESCRIPTION

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

PRESCRIPTION DRUG

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

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

PREVENTIVE CARE

Medical services provided by or upon the direction of a DOCTOR or OTHER PROVIDER related to the prevention of disease.

PRIMARY CARE PROVIDER (PCP)

An IN-NETWORK PROVIDER who has been designated by BCBSNC as a PCP.

PRIOR REVIEW

The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in CERTIFICATION or NONCERTIFICATION of benefits.

PROSTHETIC APPLIANCES

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

PROVIDER

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

REGISTERED NURSE (RN)

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

RESPIRE CARE

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

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

SHORT-TERM REHABILITATIVE THERAPY

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

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

SKILLED NURSING FACILITY

GLOSSARY *(cont.)*

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

SPECIALIST

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

SPECIALTY DRUG(S)

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

STABILIZE

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

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.

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.

OTHER IMPORTANT PLAN INFORMATION

Summary Plan Description

The following information, together with the information contained in the benefit booklet furnished to EMPLOYEES by the PLAN ADMINISTRATOR, is intended to furnish the Summary Plan Description required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA):

Name and Number of PLAN(S)

Plan Number 501 - Family Dollar Stores, Inc. Medical Plan

Name, Address and Telephone Number of PLAN SPONSOR

Family Dollar Stores, Inc.
10301 Monroe Road
Matthews, NC 28105
704-847-6961

EMPLOYER Identification Number of PLAN SPONSOR

56-0942963

Identification of PLAN ADMINISTRATOR

Health & Welfare Administrative Committee
c/o Family Dollar Stores, Inc.
10301 Monroe Road
Matthews, NC 28105

Benefits Provided by PLAN(S)

Medical Insurance - The specific coverages provided by the PLAN are set forth in your benefit booklet.

Type of PLAN ADMINISTRATION

The general administration of the PLAN is provided by the PLAN SPONSOR under Policy Number 008617 issued to the PLAN SPONSOR by Blue Cross and Blue Shield of North Carolina.

Contributions to the Cost of the PLAN(S)

The cost of the medical plan is paid by the EMPLOYER and the EMPLOYEES. The amount of EMPLOYEE contributions is determined by the EMPLOYER on an annual basis and is communicated in the annual enrollment materials. EMPLOYEE contributions can be made on a pretax basis.

Financial Records

The financial records of the PLAN(S) are kept on a Plan Year basis. Each PLAN year ends December 31.

Agent for Service of Legal Process

It is not anticipated that it will ever be necessary to have a lawsuit; however, if a lawsuit is to be brought, legal process may be served on the PLAN ADMINISTRATOR at the address above.

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.

OTHER IMPORTANT PLAN INFORMATION (cont.)

- 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.
- Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONS under your group's health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from BCBSNC or the PLAN ADMINISTRATOR when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a PRE-EXISTING CONDITION exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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's list of covered prescription drugs. You can also request updates about when a drug may become covered.
- Receive clear and correct facts to help you make your own health care choices
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage
- Participate with practitioners in making decisions about your health care
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC
- Make recommendations regarding BCBSNC's member rights and responsibilities policies
- Receive information about BCBSNC, its services, its practitioners and providers and members' rights and responsibilities
- Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service
- Read your BCBSNC benefit booklet and all other BCBSNC member materials
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24-hours notice.
- Play an active part in your health care
- Be polite to network doctors, their staff and BCBSNC staff
- Tell BCBSNC if you have any other group coverage
- Notify your Human Resources Contact Center of any changes regarding dependents and marital status within 31 days of the event
- Protect your BCBSNC ID card from improper use
- Comply with the rules outlined in your member benefit guide.





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Family Dollar Stores, Inc.
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BlueOPTIONSSM

Family Dollar Stores, Inc.

**Group Effective Date:
January 1, 2012**



An Independent Licensee of the Blue Cross and Blue Shield Association