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[RECENT CHANGES]

[Variable text]

GETTING STARTED WITH [PRODUCT NAME]

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN:

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

Please note that each year prior to the end of the current plan year, your EMPLOYER may change: (1) the method by which health insurance plans are made available to employees; (2) the amount of money contributed toward your insurance premiums; (3) the level of coverage available; and/or (4) the health insurance plans that are available to employees.]

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

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

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them, if this health benefit plan includes copayments. Copayments are not credited to the deductible; however, they are credited to the TOTAL OUT-OF-POCKET LIMIT.
Deductible	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under this health benefit plan. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.
Coinsurance	The sharing of charges by BCBSNC and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND NAME drugs, premiums, and charges for noncovered services.

Here is an **example** of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. The scenario is a total outpatient HOSPITAL bill of \$5,000. [SEL→][The ALLOWED AMOUNTS listed below are examples that reflect approximate costs of the different types of PROVIDERS.

	IN-NETWORK TIER 1	IN-NETWORK Tier 2	OUT-OF-NETWORK
A. Total Bill	\$5,000	\$5,000	\$5,000
B. ALLOWED AMOUNT	\$3,825	\$4,250	\$4,500
C. Deductible Amount	[\$1,000]	[\$1,000]	[\$2,000]
D. ALLOWED AMOUNT Minus Deductible (B-C)	[\$2,825]	[\$3,250]	[\$2,500]
E. Your Coinsurance Amount (x% times D)	[(20%)] [\$565]	[(40%)] [\$1,300]	[(50%)] [\$1,250]
F. Amount You Owe Over ALLOWED AMOUNT	\$0 (IN-NETWORK charges limited to ALLOWED AMOUNT)	\$0 (IN-NETWORK charges limited to ALLOWED AMOUNT)	\$500 (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	[\$1,565]	[\$2,300]	[\$3,750]

]
[COP; HDHP→]

	IN-NETWORK	OUT-OF-NETWORK
A. Total Bill	\$5,000	\$5,000
B. ALLOWED AMOUNT	\$4,250	\$4,250
C. Deductible Amount	[COP →] [\$1,000] [HDHP →] [\$2,000]	[COP; →] [\$2,000] [HDHP →] [\$4,000]
D. ALLOWED AMOUNT Minus Deductible (B-C)	[COP →] [\$3,250] [HDHP →] [\$2,250]	[COP →] [\$2,250] [HDHP →] [\$250]
E. Your Coinsurance Amount (x% times D)	[COP →] [(40%)] [\$1,300] [HDHP →] [(40%)] [\$900]	[COP →] [(70%)] [\$1,575] [HDHP →] [(70%)] [\$175]
F. Amount You Owe Over ALLOWED AMOUNT	\$0 (IN-NETWORK charges limited to ALLOWED AMOUNT)	\$750 (difference between Total Bill and ALLOWED AMOUNT)
G. Total Amount You Owe (C+E+F)	[COP →] [\$2,300] [HDHP →] [\$2,900]	[COP →] [\$4,325] [HDHP →] [\$4,925]

]

Deductible and coinsurance amounts are for example only, please refer to “Summary of Benefits” for your benefits.

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

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

[HDHP →] [Please note: The [Product Name] plan is intended to be a high deductible health plan (“HDHP”) that qualifies its MEMBERS to contribute to a Health Savings Account (HSA), unless its MEMBERS are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the deductible and TOTAL OUT-OF-POCKET LIMIT

amounts listed in the “Summary of Benefits” may be revised each year in accordance with Internal Revenue Service (IRS) rulings.]

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in “Glossary” at the end of this benefit booklet. The terms “we,” “us,” and “BCBSNC” refer to Blue Cross and Blue Shield of North Carolina.

For Help in Reading this Benefit Booklet

BCBSNC provides consumer assistance tools and services for individuals living with disabilities (including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. BCBSNC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call [XXX-XXX-XXXX]. For TTY and TDD, call [XXX-XXX-XXXX].

Getting Help in Other Languages

[English

This Notice has Important Information. This notice has important information about your application or coverage through BCBSNC. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call [X-XXX-XXX-XXXX].

Spanish

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de BCBSNC. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al [X-XXX-XXX-XXXX].

Chinese

槽鏢箒槎霽蹤軒拵の槽鏢箒槎龔榭拵鏹鏹陽南!TCN!鶉坵綵髹綑!CDCTOD!暖傘綵!
礎迄擯滢鯽綵蹤軒拵の迄礎掩槽鏢箒內綵霽蹤梘榭の拵鼻菓條蹤炸擻泮梘榭僅吳啁噢賍哲← 偽滢礎拵
綵剩幅滢鯽擯瑩礪趨鄴の拵槎湍吡十鄴偽拵綵漣辨戒吭槽軒拵无悼咱の迄杈鯨鞦!炸滁陽南拵巾[X-
XXX-XXX-XXXX]^!

!

Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình BCBSNC. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số [X-XXX-XXX-XXXX].

Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 BCBSNC를 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. [X-XXX-XXX-XXXX]로 전화하십시오..

French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de BCBSNC. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez [X-XXX-XXX-XXXX].

Arabic

يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال في توارىخ معينة للحفاظ على تغطيتك ابحث عن التوارىخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء التكاليف. لك الحق في الحصول على [X-XXX-XXX-XXXX]. BCBSNC. الصحية او للمساعدة في دفع المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب

Hmong

Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm BCBSNC. Saib cov caij nyooog los yog tej hnuv tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyooog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau [X-XXX-XXX-XXXX].

Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через BCBSNC. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону [X-XXX-XXX-XXXX].

Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng BCBSNC. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa [X-XXX-XXX-XXXX].

Gujarati

આ સર્વ ન મ ાં અગત્વી મ હહતી છે. આ સર્વ ન મ ાં તમ રી અરજી અથિ BCBSNC દ્ર ર સકાં ળ િ ની અગત્વી મ હહતી છે. આ સર્વ ન મ નાં િ ખ સ ત રીખો જ ઓ. તમ ે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથ ે મદદ કરવા માટે અમકુ રોક્કસ મદુ તો દ્વારા પગલાં લેવાની જરૂર છે. તમને ેઆ મ હહતી અને મદદ તમ રી લ ષ મ ાં વિન મલૂ રે મેળિ િ નો અવિક ર છે. આ [X-XXX-XXX-XXXX] સપાં ક ય કરો.

Mon-Khmer, Cambodian

បសចកកិច្ចនៃណិសបនេះ ម្តងពី្រម្តងយ៉ា៉ាងសំខាន់ ។ បសចកកិច្ចនៃណិសបនេះ ម្តងពី្រម្តងយ៉ា៉ាងសំខាន់ អុំពី្រប្រុងអនេ ឬ កាអាំងង អស្តម្ភតាមរយៈ BCBSNC ។ សូមអសែងអកាលអិបនេសំខាន់ៗ ចៅកនុងបសចកកិច្ចនៃណិសបនេះ ។ អ្នកប្រែសេសជាប្រែ្រកាអបេញសកមមភាព ែសកំណែ្រម្តងកំចាសំខាន ែបើមើមីងអកេ្រកាអាំងងសុខភាពអស្តម្ភ ឬ្រកំនិទ្ទយបេញ្រម្ត ។ អ្នកម្តងសំេងេ្រសពី្រម្តងនេះ ងងនិទ្ទយចៅកនុងកាលអស្តម្ភកេ្របាយមិទអ្សលុយប ើយ ។ សូមេ្រសំេង [X-XXX-XXX-XXXX]

German

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch BCBSNC. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter [X-XXX-XXX-XXXX].

Hindi

इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या BCBSNC के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें लिखें। अपना स्वास्थ्य बीमा बनाए रखने या अगिल्लों में मिडि के लिए आपको कुछ ननक्श्चत समयसीमा क तक कार-स रवाई करने की जरूरत हो सकती है। आपको कोई कीमत दिए बबना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। [X-XXX-XXX-XXXX] पर कॉलि करें।

Laotian

ການແຈ້ງການນ ັມ ຂໍ້ມູນສໍາຄັນ. ການແຈ້ງການນ ັມ ຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກຫຼືການຄ ັ້ມຄອງຂອງທ່ານໂດຍຜ່ານ BCBSNC. ເບິ່ງສໍາລັບກໍານົດວັນທີ່ສໍາຄັນໃນແຈ້ງການນ ັ້. ທ່ານອາດຈໍາເປັນຕ້ອງໃຊ້ເວລາດໍາເນ ນການໂດຍກໍານົດເວລາທີ່ແນ່ນອນ ຈະຮັກສາການຄ ັ້ມຄອງສ ຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ອ ັ້ມ ຄໍາໃຊ້ຈ່າຍ. ທ່ານມ ສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນ ັ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ອ ັ້ມ ຄໍາໃຊ້ຈ່າຍ. ໂທ [X-XXX-XXX-XXXX].

Japanese

この通知には重要な情報が含まれています。この通知には、BCBSNCの申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。[X-XXX-XXX-XXXX]までお電話ください。]

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

<p>BCBSNC Website: bcbnsnc.com</p>	<p>Find IN-NETWORK PROVIDERS and, get information about top-performing facilities, PRESCRIPTION DRUG information, and information about BCBSNC.</p>
<p>Blue Connect Website: [website]</p>	<p>Use our secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.</p>
<p>BCBSNC Customer Service: [X-XXX-XXX-XXXX] TTY/TDD: [X-XXX-XXX-XXXX]</p>	<p>For questions about your benefits, claims, and new ID CARD requests, or to voice a complaint.</p>
<p>PRESCRIPTION DRUG Information: [X-XXX-XXX-XXXX] or [website]</p>	<p>You may visit our website or call BCBSNC Customer Service to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to prior review, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit [www.bcbnsnc.com/umdrug] for more information.</p>
<p>[SGEX→][SHOP [X-XXX-XXX-XXXX] [healthcare.gov]</p>	<p>For questions regarding your eligibility and enrollment in health insurance plans offered in the Federal Small Business Health Options Program (SHOP). See “Glossary” for a definition of the SHOP.]</p>
<p>PRIOR REVIEW and CERTIFICATION: MEMBERS call: [X-XXX-XXX-XXXX] PROVIDERS call: [X-XXX-XXX-XXXX]</p>	<p>Some services need PRIOR REVIEW and CERTIFICATION from BCBSNC . Up to date information about which services may need PRIOR REVIEW can be found online at [website].</p>
<p>[Magellan Behavioral Health]: [X-XXX-XXX-XXXX]</p>	<p>BCBSNC delegates the administration of mental health and substance abuse benefits by contract to [Vendor Name], which is not associated with BCBSNC. See Delegated Utilization Management for more information.</p>
<p>Out of North Carolina Care: [X-XXX-XXX-BLUE (XXXX)]</p>	<p>For help in obtaining care outside of North Carolina or the U.S., call this number or visit bcbnsnc.com.</p>
<p>[HealthLine BlueSM]: [X-XXX-XXX-XXXX]</p>	<p>Talk to a nurse 24/7 to get timely information and help on a number of health-related issues. Nurses are on hand by phone in both English and Spanish.</p>
<p>[FTF→][[Vendor Name]: [X-XXX-XXX-XXXX] or [website]</p>	<p>For 24/7 access to a DOCTOR regarding nonemergency medical issues, call or visit the website to ask for a consultation. DOCTORS will be able to diagnose and suggest a treatment that’s appropriate.]</p>
<p>[BCBSNC Health Management Programs [Condition Care]: [X-XXX-XXX-XXXX]</p>	<p>For information about programs and support for handling specific health conditions, such as asthma, diabetes, heart failure, coronary artery disease and COPD.</p>
<p>[Condition Care Maternity]:</p>	<p>For information about programs and support for managing your pregnancy.</p>

[X-XXX-XXX-XXXX] or [website]	
[Healthy Outcomes] Customer Service: [X-XXX-XXX-XXXX]	Talk with a representative to get help with any technical issues with the website, as well as questions about the [Healthy Outcomes]program.
Medical Claims Filing: [Address]	Mail completed medical, pediatric dental and vision claims to this address.
PRESCRIPTION DRUG Claims Filing: [Address]	Mail completed PRESCRIPTION DRUG claims to this address.

Value-Added Programs

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

[Chiropractic Services] [X-XXX-XXX-XXXX]	For information about discounts on chiropractic services and a practitioner directory, call or visit [website] .
[TruHearingSM] [X-XXX-XXX-XXXX] [X-XXX-XXX-XXXX (TTY toll-free)]	For information about discounts on hearing aids, call or visit [website] .
[Blue365TM] [X-XXX-XXX-XXXX]	Health and wellness information support and services, and special MEMBER savings available 365 days a year.
[[Davis Vision[®]] [X-XXX-XXX-XXXX]	For information about discounts on corrective laser eye surgery, call or visit [website].]

SUMMARY OF BENEFITS

This section provides a summary of your [Product Name] 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:

- If applicable, multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- **[SEL→]**[Benefits for some PROVIDERS (hospitals and designated SPECIALISTS in cardiology, orthopedics, gastroenterology, general surgery, neurology, endocrinology, and [ob/gyn] may vary depending on the IN-NETWORK tier classification and whether or not the PROVIDER is either Tier 1 or Tier 2. Please visit our website at bcbsnc.com and use the PROVIDER search tool or call BCBSNC Customer Service at the number listed in “Who to Contact?” to find out the tier designation of IN-NETWORK PROVIDERS. Please note that PCP’s are not tiered, and not all SPECIALISTS are tiered. The list of IN-NETWORK PROVIDERS, and their tier designations, may change from time to time.]
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- **[w/HSA; w/HRA→]**[If a MEMBER uses **[w/HSA→]**[Health Savings Account (HSA)][**w/HRA→**][Health Reimbursement Account (HRA)] funds to pay their PROVIDER and the PROVIDER refunds money to the MEMBER as a result of an overestimation of the MEMBER’S deductible or coinsurance, the MEMBER must return this money to the **[w/HSA→]**[HSA][**w/HRA→**][HRA] in order to avoid any tax impacts.]

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the [Product Name] network before receiving care. Find a PROVIDER on our website at bcbsnc.com or call BCBSNC Customer Service at the number listed on your ID CARD or in “Who to Contact?”

HOW [PRODUCT NAME] WORKS

[SEL→][This health benefit plan has three benefit levels: IN-NETWORK Tier 1, IN-NETWORK Tier 2 and OUT-OF-NETWORK. Your level of benefit corresponds to how some IN-NETWORK PROVIDERS are classified into tiers based on certain performance standards. The primary categories that drive how these IN-NETWORK PROVIDERS are classified concern their performance on both quality and cost measures involving the delivery of health care. IN-NETWORK PROVIDERS that achieve both the selected quality and cost measures are placed in Tier 1.

Classification of a given IN-NETWORK PROVIDER into Tier 2 does not always mean that both quality and cost measures were not met, but may indicate that only one of those measures was not met. Similarly, classification of certain IN-NETWORK PROVIDERS as Tier 1 does not always mean a higher performance on quality and cost measures, if that classification was made due to critical access needs. Please note that certain PROVIDER specialties were not tiered against quality or cost performance measures at all, and in those cases all such PROVIDERS were designated Tier 1.

Services from a PROVIDER classified as an IN-NETWORK PROVIDER in Tier 1 will give you the richest level of benefits. You will still receive IN-NETWORK benefits when choosing an IN-NETWORK Tier 2 PROVIDER, but at a lower level than if you had chosen an IN-NETWORK Tier 1 PROVIDER. If an IN-NETWORK Tier 1 PROVIDER is not available in your area, and you visit an IN-NETWORK Tier 2 PROVIDER, your benefits will be paid at the IN-NETWORK Tier 2 benefit level. Please note that BCBSNC will examine the quality scores on an annual basis to determine if IN-NETWORK PROVIDERS need to be reclassified. To get the most of your health care benefits, it is important before receiving medical care to visit our website at [website] and use our cost comparison tools to help you determine how to make smart health care decisions and maximize your benefits. You can also use the PROVIDER search tool on our website to find the tier classification of our IN-NETWORK PROVIDERS. The IN-NETWORK PROVIDERS will be identified as either Tier 1 or Tier 2.

The following example will help you understand the difference in cost to you when exploring your treatment options and where you receive the treatment:

Service Description	IN-NETWORK Tier 1	IN-NETWORK Tier 2	OUT-OF-NETWORK
Orthopedic surgical procedure in outpatient setting	Your cost: [XX %*]	Your cost: [XX %*]	Total Charge: [\$XXXX] Your cost: [XX %*]
OFFICE VISIT to cardiologist	Your cost: [\$XX copayment]	Your cost: [\$XX copayment]	Total Charge: [\$XXXX] Your cost: [XX %*]

*The examples above only show your coinsurance amount, please note that your deductible must be met first.]

As a MEMBER of the [Product Name] 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 [Product Name] 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 our website at bcbnsnc.com or call BCBSNC Customer Service at the number listed in “Who to Contact?” Here is a look at how it works:

	IN-NETWORK [SEL→][Tier 1 or Tier 2]	OUT-OF-NETWORK
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the [Program Name®] program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate	OUT-OF-NETWORK PROVIDERS are not designated as a [Product Name] PROVIDER by BCBSNC. Also see “OUT-OF-NETWORK Benefit Exceptions.”

	IN-NETWORK [SEL→][Tier 1 or Tier 2]	OUT-OF-NETWORK
	<p>in the [Program Name[®]] program. See “Glossary” for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received.</p> <p>The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on our website at bcbsnc.com, or call BCBSNC Customer Service at the number listed in “Who to Contact?”</p>	
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and noncovered expenses. (See Filing Claims below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable copayment, deductible, coinsurance, and noncovered expenses. For EMERGENCY SERVICES, see “OUT-OF-NETWORK Benefit Exceptions” and “Emergency Care” for additional information.
Referrals	BCBSNC does not require you to obtain any referrals.	
After-hours Care	If you need nonemergency services after your PROVIDER’S office has closed, please call your PROVIDER’S office for their recorded instructions.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard [®] Program, and benefits are provided at the IN-NETWORK [SEL→][Tier 1]benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see “OUT-OF-NETWORK Benefit Exceptions.”
PRIOR REVIEW	<p>IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW when necessary.</p> <p>IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans’ Affairs (VA) and military PROVIDERS, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC or its designee even if you see an IN-NETWORK PROVIDER.</p> <p>See “Who to Contact?” for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance abuse services and all other medical services.</p>	You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER, in or outside of North Carolina, requests PRIOR REVIEW by BCBSNC or its designee when necessary. See “Who to Contact?” for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance abuse services and all other medical services. Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. However, PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.

	IN-NETWORK [SEL→][Tier 1 or Tier 2]	OUT-OF-NETWORK
	PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, you will need to return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. 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.

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at the IN-NETWORK [SEL→][Tier 1]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" in "COVERED SERVICES" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC's access to care standards, see our 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 [Product Name] MEMBER. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.

For ID CARD requests, please visit our website at [website] or call BCBSNC Customer Service at the number listed in "Who to Contact?"

The Role of a primary care provider (PCP) or specialist

BCBSNC does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care needs. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

Please visit our website at bcbsnc.com and click on [Find a Doctor] or call BCBSNC Customer Service to confirm that the PROVIDER is in the network before receiving care.

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

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

To make this request or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call BCBSNC Customer Service at the number listed in “Who to Contact?”

COVERED SERVICES

[Product name] 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 full denial of benefits. General categories of services are noted below as requiring PRIOR REVIEW. Also see “PRIOR REVIEW/Pre-Service” in “UTILIZATION MANAGEMENT” for information about the review process, visit our website at [website], 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 [Product Name], its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.
- Certain services are covered pursuant to BCBSNC medical [FTF→] [and reimbursement] policies, which are updated throughout the plan year. These policies lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, cosmetic, a convenience item, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. The most up-to-date medical [FTF→] [and reimbursement] policies are available at bcbnsnc.com, or call BCBSNC Customer Service at the number listed in “Who to Contact?”
- From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services or therapies in connection with programs designed to reduce medical costs.

Office Services

Care you receive as part of an OFFICE VISIT, electronic visit, [FTF→] [telemedicine,] or house call is covered, except as otherwise noted in this benefit booklet. [FTF→] [Telemedicine services include evaluation, management and consultation services for nonemergency medical issues with a PROVIDER via an interactive audio/video telecommunications system. [See [Vendor Name] in “Who to Contact?” to access a DOCTOR who can diagnose and recommend treatment.] Telemedicine services [from [Vendor Name]] will be subject to your PCP copayment and/or coinsurance and any applicable deductible. You can also check with your PROVIDER to see if telemedicine services are available; your benefit will depend on the type of PROVIDER supplying these services.]

If this health benefit plan has a copayment for PCP OFFICE VISITS, a copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT. If this health benefit plan has copayments for PCP or SPECIALIST OFFICE VISITS, certain office SURGERIES for the treatment of sinus disease are subject to deductible and coinsurance. Certain office SURGERIES may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

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

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

Office Services Exclusion

- Certain self-injectable PRESCRIPTION DRUGS that can be self-administered. The list of these drugs may change from time to time. See our website at 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

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

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

Federally-Mandated PREVENTIVE CARE Services

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

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

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

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

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

Situation	Example	Reason/Result
How your PREVENTIVE CARE service is filed	A colonoscopy includes a primary diagnosis of non-preventive.	Certain PREVENTIVE CARE services will not pay in full because the primary diagnosis filed on the claim is something other than PREVENTIVE CARE. In this instance, the colonoscopy is subject to any applicable copayment, deductible or coinsurance.
Type of PREVENTIVE CARE service	A routine exam includes an additional procedure, such as a urinalysis.	This urinalysis will not be paid in full because it is not identified as a federally-mandated PREVENTIVE CARE service. This service is subject to any applicable copayment, deductible or coinsurance.

Place of service (where you receive your PREVENTIVE CARE service)	A mammogram is performed in a setting (inpatient) that is not considered an office, such as a HOSPITAL.	Certain PREVENTIVE CARE services will not be paid in full because they are not performed in an office-based, outpatient or ambulatory setting or URGENT CARE center. In this example, the mammogram is subject to deductible and coinsurance.
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[COP; COI; SEL→] [Most PREVENTIVE CARE services performed by OUT-OF-NETWORK PROVIDERS are not covered. However, the following list of services is mandated by the state of North Carolina and is available OUT-OF-NETWORK. If you see an OUT-OF-NETWORK PROVIDER for these services, your benefits will be subject to the OUT-OF-NETWORK benefit level.]

State-Mandated PREVENTIVE CARE Services:

Bone Mass Measurement Services

This health benefit plan covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your benefit level for the location where services are received.

Qualified individuals include MEMBERS who have any one of the following conditions:

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

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic MEMBER who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings. Lab work done as a result of a colorectal screening exam will be covered under your diagnostic benefit and not be considered PREVENTIVE CARE. It will be subject to your benefit level for the location where services are received. However, lab work for the removal of polyps during the screening exam is considered PREVENTIVE CARE.

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

Gynecological Exam and Cervical Cancer Screening

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

Newborn Hearing Screening

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

Ovarian Cancer Screening

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

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

Prostate Screening

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

Screening Mammograms

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

A female MEMBER is “at risk” if she:

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

PREVENTIVE CARE Exclusions

- Immunizations required for occupational hazard or international travel
- Fitting for contact lenses, glasses or other hardware
- Diagnostic services that are not a component of a routine vision examination.

Obesity Treatment/Weight Management

This health benefit plan provides coverage for OFFICE VISITS for the evaluation and treatment of obesity; see “Summary of Benefits” for visit maximums. Benefits are also provided for surgical treatment of morbid obesity (bariatric surgery) [if you have received 12 consecutive months of medical management of this condition prior to the surgical procedure]. You may want to go to a Blue Distinction Center for Bariatric Surgery[®], which is a hospital that has been designated as delivering quality specialty care. Visit [website] to find a Blue Distinction Center for Bariatric Surgery[®] near you. Bariatric surgery services require PRIOR REVIEW and CERTIFICATION or services will not be covered. Coverage is also provided for PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of obesity. See “PRESCRIPTION DRUG benefits.”

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

Obesity Treatment/Weight Management Exclusions

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

Diagnostic Services

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

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

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

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

Diagnostic Services Exclusion

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

emergency Care

This health benefit plan provides benefits for EMERGENCY SERVICES.

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

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

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

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. If you are unsure if your condition is an EMERGENCY, you can call [Vendor Name], and a [Vendor Name] 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 an IN-NETWORK HOSPITAL emergency room.	Applicable ER copayment, deductible and/or coinsurance. PRIOR REVIEW and CERTIFICATION are not required.
You go to an OUT-OF-NETWORK HOSPITAL emergency room.	Benefits paid at the IN-NETWORK [SEL→][Tier 1]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) or services will be denied. You may need to transfer to an IN-NETWORK HOSPITAL once your condition is stabilized in order to continue receiving IN-NETWORK benefits.
You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged.	Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.

URGENT CARE

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

Family Planning

Maternity Care

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

	Mother	Newborn	Payment	
Prenatal care	Care related to the pregnancy before birth.		A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Otherwise, coinsurance and any applicable deductible 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	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	[COP; COI; SEL→] [For the first 48/96 hours only one BENEFIT PERIOD deductible and admission copayment, if applicable, is required for both mother and baby.	[HDHP→] [Deductible and coinsurance apply. If adding the baby changes your policy from EMPLOYEE to family coverage, the family BENEFIT PERIOD deductible applies.]

	within 72 hours of discharge.	loss. (Please see PREVENTIVE CARE in “Summary of Benefits.”)		
Post-delivery services	All care for the mother after the baby’s birth that is related to the pregnancy. PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours or services will be denied.	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 or services will be denied.	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 “Who to Contact?”

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

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

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

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

[N-EXRO & N-EXROC & SGOFF→][Termination of Pregnancy (Abortion)]

Benefits for abortion are available through the first 16 weeks of a pregnancy for all female MEMBERS except DEPENDENT CHILDREN.]

COMPLICATIONS OF PREGNANCY

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

INFERTILITY Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS. Benefits are provided for a combined IN- and OUT-OF-NETWORK LIFETIME MAXIMUM per MEMBER for each of the specific services listed below associated with three medical ovulation induction cycles, with or without insemination, unless otherwise noted. This LIFETIME MAXIMUM applies to a cumulative number of INFERTILITY treatments with the following services, provided in all places of service.

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

See “Summary of Benefits” for limitations that apply on ovulation induction cycles. For information about coverage of prescription drugs for infertility, see “Prescription Drug Benefits.” BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. For more information about medical policies on infertility, see our website at bcbsnc.com and search on [“infertility”], or call Customer Service at the number listed in “Who to Contact?”

SEXUAL DYSFUNCTION Services

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

[N-EXRO→][Sterilization

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

[N-EXROC→][Certain sterilization procedures for female MEMBERS are covered under your PREVENTIVE CARE benefit. See [www.bcbsnc.com/preventive] or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.]]

[N-EXRO→][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. [N-EXROC→][Certain FDA-approved contraceptive methods for female MEMBERS are covered under your PREVENTIVE CARE benefit. See [www.bcbsnc.com/preventive] or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.]



See “PRESCRIPTION DRUG Benefits” for coverage of oral contraceptives.]

Family Planning Exclusions

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

- Care or treatment of the following:
 - **[N-EXRO& N-EXROC & SGOFF→]**[elective termination of pregnancy (abortion) for DEPENDENT CHILDREN]
 - **[N-EXRO & N-EXROC & SGEX; N-EXRO & N-EXROC & EXETP & SGOFF→]**[elective termination of pregnancy (abortion), except within the first 16 weeks of pregnancy for female SUBSCRIBERS and enrolled spouses of the SUBSCRIBERS when the life of the mother would be endangered if the unborn child was carried to term or the pregnancy is the result of rape or incest]
 - **[EXRO; EXROC→]**[elective termination of pregnancy (abortion)]
 - **[EXRO →]**[sterilizations have been excluded as a result of a religious exemption claimed by your EMPLOYER]
 - **[EXRO→]**[contraceptive devices have been excluded as a result of a religious exemption claimed by your EMPLOYER]
 - reversal of sterilization.
 - **[N-EXRO & N-EXROC & SGOFF→]**[Elective termination of pregnancy (abortion) after 16 weeks of pregnancy]
- 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
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the [PPO] network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE. Take home drugs are covered as part of your PRESCRIPTION DRUG benefit.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See “Maternity Care” and “EMERGENCY Care.” IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. **If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, services will be denied.** Also, BCBSNC requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined IN- and OUT-OF-NETWORK day maximum per BENEFIT PERIOD. See “Summary of Benefits.”

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC or services will be denied. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Other Services

Ambulance Services

This health benefit plan covers services in a ground ambulance traveling:

- From a MEMBER’S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY

when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition.

Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER’S home when MEDICALLY NECESSARY.

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

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

Ambulance Service Exclusions

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

Blood

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

Blood Exclusion

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

Certain Drugs Covered under Your Medical Benefit

This health benefit plan covers certain PROVIDER-ADMINISTERED SPECIALTY DRUGS that must be dispensed under a PROVIDER'S supervision in an office, outpatient setting, or through home infusion. These drugs are covered under your medical benefit rather than your PRESCRIPTION DRUG benefit. Coverage of some of these drugs may be limited to certain PROVIDER settings (such as office, outpatient, AMBULATORY SURGERY CENTER or HOME HEALTH AGENCY). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit our website at bcbsnc.com.

Clinical Trials

This health benefit plan provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of cancer or a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical SPECIALISTS
- Be approved by centers or groups funded by the National Institutes of Health, the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

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

Dental Treatment Covered Under Your Medical Benefit

For MEMBERS who may have additional dental care benefits, see "Pediatric Dental." This health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of

dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

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

This health benefit plan provides benefits for dental implants and related procedures, such as bone grafting, associated with the above three conditions.

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

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

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

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

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

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

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

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

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 BCBSNC. BCBSNC provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer MEDICALLY NECESSARY.

Certain durable medical equipment requires prior review and certification or services will not be covered.

Durable Medical Equipment Exclusions

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

Hearing Aids

This health benefit plan provides coverage for MEDICALLY NECESSARY hearing aids , including implantable bone-anchored hearing aids (BAHA) and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER under the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER’S needs. When covered, benefits for hearing aids are limited to one hearing aid per hearing-impaired ear every 36 months for MEMBERS under age 22. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds.

HOME HEALTH Care

HOME HEALTH care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN), and/or other skilled care services like REHABILITATIVE THERAPY and HABILITATIVE SERVICES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a HOME HEALTH aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

HOME HEALTH care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

HOME HEALTH Care Exclusions

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

Home Infusion Therapy Services

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

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

HOSPICE Services

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

HOSPICE Services Exclusion

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

Lymphedema-Related Services

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

MEDICAL SUPPLIES Exclusion

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

Orthotic Devices

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

Orthotic Devices Exclusions

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

Pediatric DENTAL SERVICES

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

Diagnostic and Preventive Services

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

- Oral evaluations
 - periodic (twice per BENEFIT PERIOD)
 - comprehensive oral or periodontal (limit one per PROVIDER and one per BENEFIT PERIOD, counts toward periodic frequency limit above)

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

Basic and Major Services

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

- Routine fillings to restore diseased teeth (limit of one restoration per tooth every two years, unless new decay appears)
 - Amalgam - a soft silver which hardens after it is packed into the cavity
 - Composite resin or other tooth-colored filling materials
- X-rays
 - Extraoral (two films per benefit period)
- Simple extractions
- Stainless steel crowns
 - Primary posterior (one per tooth per lifetime)
 - Primary anterior (one per tooth every three years)
 - Permanent (one per tooth every eight years)
- Pin retention (limit of once per restoration)
- Surgical removal of teeth
- Complex oral surgery
 - Oroantral fistula closure/closure of sinus perforation (once per tooth)
 - Surgical access of unerupted tooth/process to aid eruption (once per tooth)
 - Transseptal fiberotomy (once per site every three years)
 - Alveoloplasty (once per site every three years)
 - Vestibuloplasty (once per site every three years)
 - Removal of exostosis (once per site every three years)
 - Incision and drainage of intraoral abscess
 - Frenulectomy (once per site per lifetime)
 - Excision of hyperplastic tissue or pericoronal gingival (once per site every three years)
- Anesthesia limited to deep sedation and intravenous when CLINICALLY NECESSARY and related to covered complex surgery or surgical removal of teeth when three or more quadrants are involved
- Inlays, onlays, crowns (one restoration per tooth every eight years, covered only when a filling cannot restore the tooth)

- Core build-up, cast post and core (one per tooth every eight years)
- Labial veneers, anterior only (one per tooth every five years)
- Complete dentures (once every eight years, no additional allowances for over-dentures or customized dentures)
- Removable partial dentures (once every eight years, no additional allowances for precision or semi-precision attachments)
- Fixed partial dentures (once every eight years, no additional allowances for removable partial dentures)
- Tissue conditioning done more than six months after initial insertion or rebasing or relining (once per 12 months per prosthesis)
- Denture relining done more than six months after the initial insertion (once every two years)
- Rebasing of complete and partial dentures done more than five years after the initial insertion (once every five years)
- Crown, partial and complete denture repairs and addition of teeth to existing partial dentures (limited to repairs or adjustments done after 12 months following the initial insertion)
- Replacement of broken teeth on partial or complete denture (once per tooth every three years)
- Recementing of inlays, onlays, crowns and/or fixed partial dentures
- Occlusal guard, for treatment of bruxism only (once every five years)
- Endodontics - treatment of diseases of the nerve chamber and canals
 - Pulpotomy - partial removal of a tooth's pulp and placement of medicament (once per tooth per lifetime)
 - Retrograde filling (limit one per tooth)
 - Root amputation (limit one per tooth)
 - Endodontic therapy (once per lifetime, and retreatment once per lifetime after 12 months from initial treatment)
 - Apexification - inducing root development
 - Hemisection - dividing the crown and roots of a multi-rooted tooth (once per root per lifetime)
 - Apicoectomy - removing the infected tip of the tooth's root (once per root per lifetime)
- Periodontics – treatment of the diseases of the gums and bone surrounding the teeth
 - Crown lengthening - reshaping the bone around the teeth to allow for proper prosthetic preparation (once per tooth every three years per site or quadrant)
 - Root planing and periodontal scaling - scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every three years)
 - Full mouth debridement (once every five years)
 - Provisional splinting (once every three years)
 - Periodontal maintenance following active periodontal therapy (twice each BENEFIT PERIOD)
 - Complex surgical periodontal care (limited to one complex surgical periodontal service per area every three years):
 - Gingivectomy and gingivoplasty - cutting out diseased or overgrown gum tissues around the teeth
 - Gingival flap procedure - soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue
 - Osseous surgery—removing or reshaping the bone around the teeth through an incision of the gum
 - Bone replacement graft
 - Guided tissue regeneration
 - Soft tissue graft/allograft/connective tissue graft
 - Distal or proximal wedge
- Placement of dental implants, and any other related implantology services, including pharmacological regimens (limited to once per tooth every eight years).

Orthodontic Services

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

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

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

Pediatric Dental Exclusions

- Anesthesia, except as otherwise covered by this health benefit plan
- Attachments to conventional removable prostheses or fixed bridgework, including semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability
- Brush biopsy
- Cone beam, except as otherwise covered by this health benefit plan
- Indirect resin-based composite crowns
- Temporary or provisional crowns
- Removal of odontogenic and nonodontogenic cysts
- Cytology samples
- Dental implants when not **CLINICALLY NECESSARY**
- Dental procedures not directly associated with dental disease
- Dental procedures not performed in a dental setting
- Interim dentures
- Removable unilateral partial denture, including clasps and teeth
- Application of desensitizing materials
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- **DENTAL SERVICES** provided in a **HOSPITAL**
- Incision and drainage of abscess - extraoral soft tissue
- Maxillofacial prosthesis
- Occlusal guards for any purpose other than control of habitual grinding
- **OFFICE VISITS** for purposes of observation or presentation of treatment plan
- Orthodontic services, except as otherwise covered by this health benefit plan
- Periodontal related services such as anatomical crown exposure, apically positioned flap, surgical revisions and unscheduled charges
- Temporary or provisional pontics
- Pulp cap, direct or indirect
- Radiographs not specifically stated as covered are considered noncovered, such as skull and bone survey
- Tooth re-implantation or transplantation from one site to another
- Removal of foreign bodies or non-vital bones
- Services related to the salivary gland.

Pediatric Vision Services

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

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

Pediatric Vision Exclusions

- Services and materials not meeting accepted standards of optometric practice
- Visual therapy
- Replacement of lost or stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Replacement insurance for contact lenses.

Private Duty Nursing

This health benefit plan provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who may be receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY.

See "Care Management."

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

Private Duty Nursing Exclusion

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

PROSTHETIC APPLIANCES

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

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

PROSTHETIC APPLIANCES Exclusions

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

Surgical Benefits

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

Coverage is provided for endovenous procedures used to support the normal function of your veins, and is limited to one procedure per limb per lifetime. Benefits are also provided for sclerotherapy vein treatment and are limited to three procedures per limb per lifetime. If you need knee replacement or hip replacement surgery, you may want to go to a Blue Distinction Center, which is a HOSPITAL that has been designated as delivering quality specialty care. Visit [website] to find a Blue Distinction Center near you.

See “OFFICE SERVICES” for office SURGERY benefits when performed by a PCP or SPECIALIST.

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

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

For information about coverage of multiple surgical procedures, please refer to BCBSNC’s reimbursement policies, which are on our website at bcbsnc.com, or call BCBSNC Customer Service at the number listed in “Who to Contact?”

Anesthesia

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

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

Mastectomy Benefits

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

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

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

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

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

Temporomandibular Joint (TMJ) Services

This health benefit plan provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones.

Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving 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

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

REHABILITATIVE THERAPY and HABILITATIVE SERVICES

The following therapies are covered:

- Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation) up to a one-hour session per day
- Speech therapy.

Benefits are limited to two combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD visit maximums for each of these two categories of services:

- REHABILITATIVE THERAPY has a BENEFIT PERIOD MAXIMUM of 30 visits for occupational and/or physical therapy (including chiropractic services) and 30 visits for speech therapy.
- HABILITATIVE SERVICES has a BENEFIT PERIOD MAXIMUM of 30 visits for physical/occupational therapy (including chiropractic services) and 30 visits for speech therapy..

These visit limits apply in all places of service except inpatient (e.g., outpatient, office and home), regardless of the type of PROVIDER (chiropractors, other DOCTORS, physical therapists). REHABILITATIVE THERAPY and HABILITATIVE SERVICES received while an inpatient is not included in the BENEFIT PERIOD MAXIMUM. Benefits may vary depending on where services are received. See "Summary of Benefits" for additional information and any visit maximums.

OTHER THERAPIES

This health benefit plan covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment (three treatments per week, more treatments are available if MEDICALLY NECESSARY)
- Radiation therapy.
- Chemotherapy, including intravenous chemotherapy.

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

Therapy Exclusions

- Cognitive therapy
- Group classes for pulmonary rehabilitation.

Transplants

This health benefit plan provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. BCBSNC provides care management for transplant services and will help you find a HOSPITAL or [Vendor Name]that provides the transplant services required. Travel and lodging expenses and charges related to a search for a donor may be reimbursed based on BCBSNC guidelines that are available upon request from a transplant coordinator.

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

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

- Benefits are provided for reasonable and necessary services related to the search for a donor.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a MEMBER.
- Benefits provided to the donor will be charged against the recipient’s coverage.

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

Transplants Exclusions

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

Mental Health And Substance Abuse Services

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

Your coverage for inpatient and certain outpatient services is coordinated through [Vendor Name]. BCBSNC delegates administration of these benefits, including UTILIZATION MANAGEMENT, to [Vendor Name]. [Vendor Name] is not associated with BCBSNC. To understand more about when you need to contact [Vendor Name], see “How to Access Mental Health and Substance Abuse Services.”

OFFICE VISIT Services

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

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

Outpatient Services

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

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

Certain outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. Visit our website at **[website]** or call [Vendor Name] at the number listed in “Who to Contact?” for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

Inpatient Services

Covered inpatient treatment, and RESIDENTIAL TREATMENT FACILITY services also include:

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

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for inpatient services, except for EMERGENCIES. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK inpatient admissions, services will be denied..

RESIDENTIAL TREATMENT FACILITY Services

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for mental health and substance abuse services received in a RESIDENTIAL TREATMENT FACILITY. IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW and obtaining CERTIFICATION. If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT-OF-NETWORK RESIDENTIAL TREATMENT FACILITY services, services will be denied.

How to Access Mental Health and Substance Abuse Services

PRIOR REVIEW by [Vendor Name] is not required for any OFFICE VISIT services or in EMERGENCY situations; however, in EMERGENCY situations, please notify [Vendor Name] 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 [Vendor Name] customer service representative at the number listed in “Who to Contact?” Failure to request PRIOR REVIEW and receive CERTIFICATION will result in a full denial of benefits. The [Vendor Name] customer service representative can help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements.

Mental Health and Substance Abuse Services Exclusion

- Counseling with relatives about a patient.

prescription drug Benefits

Your PRESCRIPTION DRUG benefits cover the following:

- PRESCRIPTION DRUGS, including self-administered injectable medications**[N-EXRO→]**, and contraceptive drugs and devices]
- Certain over-the-counter drugs when listed as covered in the FORMULARY, or under your PREVENTIVE CARE benefit, and a PROVIDER’S PRESCRIPTION for that drug is presented at the pharmacy
- Spacers for metered dose inhalers and peak flow meters
- PRESCRIPTION DRUGS related to treatment of SEXUAL DYSFUNCTION
- PRESCRIPTION DRUGS approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity
- Insulin and diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

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

- Certain PRESCRIPTION DRUGS related to treatment of INFERTILITY. INFERTILITY drugs are limited to quantity LIFETIME MAXIMUMS per MEMBER. For the medical policy on INFERTILITY, see our website at bcbsnc.com [and search on “infertility”]. For information on prescription drugs that have quantity limits, see [www.bcbsnc.com/content/services/formulary/rxnotes.htm].

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

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

Situation	Value
Where you get your PRESCRIPTION filled	<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. If you fail to show your ID CARD or the IN-NETWORK pharmacy’s records do not show you as eligible for coverage, you will have to pay the full cost of the PRESCRIPTION and file a claim. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, you will need to return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.</p> <p>You may also get your PRESCRIPTION filled by an OUT-OF-NETWORK pharmacy; however, you may be asked to pay the full cost of the PRESCRIPTION DRUG and submit your own claim. Any charges over the ALLOWED AMOUNT are your responsibility.</p> <p>If you had an EMERGENCY or URGENT CARE condition and went to an OUT-OF-NETWORK pharmacy, we recommend that you call BCBSNC Customer Service at the number listed in “Who to Contact?” so that the claim can be processed at the IN-NETWORK level.</p>
How the type of PRESCRIPTION DRUG may determine the amount you pay	<p>Your PRESCRIPTION DRUG benefit has a CLOSED 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.</p> <p>Tier placement of PRESCRIPTION DRUGS in the FORMULARY may be determined by: the effectiveness and safety of the drug, the cost of the drug, and/or the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).</p> <p>[COP; SEL→] [The lowest cost PRESCRIPTION DRUGS, such as GENERICS, are generally located on the lowest tiers (Tier 1 and Tier 2). Higher cost PRESCRIPTION DRUGS, such as BRAND-NAME PRESCRIPTION DRUGS are generally located on the higher tiers (Tier 3 and Tier 4). All tiers of the FORMULARY may contain GENERIC and BRAND-NAME PRESCRIPTION DRUGS.</p> <p>SPECIALTY DRUGS, if applicable, are located on the highest tiers of your health benefit plan, even though they may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR PRESCRIPTION DRUGS. Visit our website at bcbsnc.com for additional information on the tier classification of PRESCRIPTION DRUGS.]</p> <p>The PRESCRIPTION DRUGS listed in the FORMULARY or their tier placement may change from time to time due to a change in the cost of the drug and/or in the classification of the drug by the U.S. Food and Drug Administration (FDA) or nationally-recognized drug databases (e.g., Medispan).</p>

	<p>From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs or to encourage members to seek appropriate, high quality, efficient care based on BCBSNC criteria.</p>
<p>How your PRESCRIPTION is dispensed</p>	<p>In some cases, a PROVIDER may prescribe a total dosage of a drug that requires two or more different drugs in a compound to be dispensed. In these cases if you have copayments for PRESCRIPTION DRUGS, you will be responsible for one copayment, that of the highest tier drug in the compound, based on each 30-day supply. Please note that some PRESCRIPTION DRUGS are only dispensed in 60- or 90-day quantities. For these drugs, you will pay either two or three copayments depending on the quantity you receive. Please see “Summary of Benefits.” Certain combinations of compound drugs may require PRIOR REVIEW and CERTIFICATION.</p> <p>If you need to receive an extended supply (greater than a 30-day supply and up to a 90-day supply), visit our website at [bcbnsnc.com] for a listing of retail pharmacies or mail-order service that can dispense an extended supply of your PRESCRIPTION.</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>
<p>If you have multiple PRESCRIPTIONS and need to align your refill dates</p>	<p>If you have multiple PRESCRIPTIONS and need to align your refill dates you may need a PRESCRIPTION for less than a 30-day supply. If your DOCTOR or pharmacy agrees to give you a PRESCRIPTION for less than a 30-day supply for this purpose you will only pay a prorated daily cost-sharing amount (any dispensing fee will not be prorated). This benefit is only available for drugs covered under your PRESCRIPTION DRUG benefit, received at an IN-NETWORK pharmacy, and when PRIOR REVIEW requirements have been met. In addition, the drugs must:</p> <ul style="list-style-type: none"> • be used for treatment and management of chronic conditions and are subject to refills; • NOT be a Schedule II or Schedule III controlled substance containing hydrocodone; • be able to be split over short-fill periods; and • do not have the quantity limits or dose optimization criteria that would be affected by aligning refill dates.
<p>Use of Lower-Cost PRESCRIPTION DRUGS</p>	<p>When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.</p> <p>[MACB; MACA →] [Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. [MACA BN →] [If your PROVIDER requires you to take, or you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT.] [MACB BN →] [If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC</p>

	<p>ALLOWED AMOUNT.]For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.]</p> <p>You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts would still apply.]</p>
PRIOR REVIEW Requirements	<p>PRIOR REVIEW and CERTIFICATION by BCBSNC are required for some PRESCRIPTION DRUGS or services will not be covered. BCBSNC may change the list of these PRESCRIPTION DRUGS from time to time.</p>
SPECIALTY DRUGS	<p>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 or less. For a list of PRESCRIPTION DRUGS that are considered SPECIALTY DRUGS, visit our website at bcbsnc.com.</p>
RESTRICTED-ACCESS DRUGS and Devices	<p>Coverage will be provided for a RESTRICTED-ACCESS DRUG or device to a MEMBER without requiring PRIOR REVIEW or CERTIFICATION or use of a nonrestricted formulary drug if a MEMBER’S physician certifies in writing that the MEMBER has previously used an alternative nonrestricted-access drug or device and the alternative drug or device has been detrimental to the MEMBER’S health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the MEMBER’S health or ineffective in treating the condition again.</p>
Exception Request	<p>Members, their authorized representative or their provider may request a standard exception request, an expedited exception request or an external exception request in order to gain access to non-formulary drugs.</p> <p>As part of an exception request, the MEMBER’S PROVIDER must provide supporting information of the request by including an oral or written statement that provides a justification supporting the need for the non-FORMULARY drug to treat the member’s condition, including a statement that all covered FORMULARY drugs on any tier (1) will be or have been ineffective; (2) would not be as effective as the non-FORMULARY drug; or (3) would have adverse effects.</p> <p>MEMBERS (or their authorized representatives) may visit [insert website] for information about the ways to submit a request. Generally, members may submit requests:</p> <ul style="list-style-type: none"> • By fax (visit the website above for fax form and numbers) • By mail to BlueCross BlueShield of North Carolina , [Healthcare Management and Operations, Pharmacy Exception, P. O. Box 2291, Durham, NC 27702] • By telephone at [1-800-672-7897] <p>Once BCBSNC has all necessary information to make a decision, BCBSNC will provide a response to the member and their provider approving or denying their</p>

request (if approved, notice will provide duration of approval) within the following timeframes:

Type of Request	BCBSNC Response	
Standard	No later than 72 hours following the receipt of request	
Expedited*	No later than 24 hours following the receipt of request	
External**	No later than 72 hours following the receipt of request (Original request was standard) No later than 24 hours following the receipt of request (original request was expedited)	

*An expedited request is permissible where a member is suffering from a health condition that may seriously jeopardize the member’s life, health, or ability to regain maximum function or when the member is getting a current course of treatment using a non-formulary drug.

**An external request will be reviewed by an independent review organization contracted by BCBSNC.

Quantity Limitations

BCBSNC covers certain PRESCRIPTION DRUGS up to a set quantity based on criteria developed by BCBSNC to encourage the appropriate use of the drug. For these PRESCRIPTION DRUGS, PRIOR REVIEW and CERTIFICATION are required before excess quantities of these drugs will be covered. When excess quantities are approved, you may be required to pay an additional copayment, if applicable.

Benefit Limitations

Certain PRESCRIPTION DRUGS are subject to benefit limitations which may include: the amount dispensed per PRESCRIPTION, per day or per defined time period; per lifetime; per month’s supply; or the amount dispensed per single copayment, if applicable. Note: excess quantities are not covered.

Where to find more information

You may visit our website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in “Who to Contact?” for the following:

- List of IN-NETWORK pharmacies (including the Specialty Network); note this list may change from time to time
- List of PRESCRIPTION DRUGS that:
 - require PRIOR REVIEW and CERTIFICATION
 - are RESTRICTED-ACCESS DRUGS and devices
 - are subject to benefit limitations
 - are subject to quantity limitations
 - must be dispensed through the Specialty Network in order to receive IN-NETWORK benefits
- Any special programs that may apply
- A copy of the FORMULARY. See [name of FORMULARY] at [FORMULARY URL].

You may also visit [www.bcbsnc.com/umdrug] for more information

PRESCRIPTION DRUG Benefits Exclusions

Any PRESCRIPTION DRUG that is:

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

And any other drug that is:

- Purchased over-the-counter, unless specifically listed as a covered drug in the FORMULARY and a written PRESCRIPTION is provided
- Therapeutically equivalent to an over-the-counter drug
- Compounded and does not contain at least one ingredient that is defined as a PRESCRIPTION DRUG (see “Glossary”). Compounds containing non-FDA approved bulk chemical ingredients are excluded from coverage.
- Contraindicated (should not be used) due to age, gender, drug interaction, therapeutic duplications, dose greater than maximum recommended or other reasons as determined by FDA’s approved product labeling.
- Also see “What Is Not Covered” for additional PRESCRIPTION DRUG exclusions.

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in “Covered Services.” Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all the exclusions that apply, read “Covered Services,” “Summary of Benefits” and “What Is Not Covered?” This health benefit plan does not cover services, supplies, drugs or charges for:

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the EMPLOYEE, EMPLOYER or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state’s workers’ compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Services received in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet

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

A

Acupuncture and acupressure

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

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

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

B

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

C

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

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

[EXRO→][**Contraceptives**, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, intrauterine devices and implanted hormonal contraceptives,

solely prescribed for the purpose of contraception. These services are excluded as a result of a religious exemption claimed by your EMPLOYER.]

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

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

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

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a **DOCTOR**. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the **PROVIDER** prescribing or providing the services.

D

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

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

The following **drugs**:

- Injections by a health care professional of injectable **PRESCRIPTION DRUGS** which can be self-administered, unless medical supervision is required
- Drugs associated with assisted reproductive technology
- **EXPERIMENTAL** drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to **PRESCRIPTION DRUGS** (1) specifically listed as a covered drug in the **FORMULARY** and a written prescription is provided; or (2) used in covered phases I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
 - The National Comprehensive Cancer Network Drugs & Biologics Compendium
 - The Thomson ® Micromedex DrugDex ®
 - The Elsevier Gold Standard’s Clinical Pharmacology
 - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

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

The following **equipment**:

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

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

F

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

G

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

H

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

Hypnosis except when used for control of acute or chronic pain

I

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

Inpatient confinements that are primarily intended as a change of environment

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

M

Services or supplies deemed not **MEDICALLY NECESSARY**

N

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

P

Body **piercing**

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

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

R

The following **residential care** services:

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

RESPITE CARE, whether in the home or in a facility or inpatient setting, except as specifically covered by this health benefit plan

S

Services or supplies that are:

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

SEXUAL DYSFUNCTION unrelated to organic disease

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

T

The following types of **therapy**:

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

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

V

The following **vision** services:

- Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES" or "Pediatric Vision"
- Orthoptics, vision training, and low vision aids, except as specifically covered in "Pediatric Vision"
- Routine eye exams for adults.

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

over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals. For the most up-to-date PREVENTIVE CARE services that are covered under federal law, see our website at [www.bcbsnc.com/preventive].

W

Wigs, hairpieces and hair implants for any reason

WHEN COVERAGE BEGINS AND ENDS

EMPLOYEES shall be added to coverage no later than 90 days after their first day of employment.

The term “EMPLOYEE” means a nonseasonal person who works full-time, 30 or more hours per week and is otherwise eligible for coverage. In some cases, and where permitted by applicable law, your EMPLOYER may allow eligibility to extend to other persons, such as retirees or part-time EMPLOYEES.

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

- Your spouse under an existing marriage that is legally recognized under any state law
- [Your [same sex] domestic partner, so long as you and your [same sex] domestic partner have attested to the GROUP ADMINISTRATOR, in writing 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 of North Carolina
 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 North Carolina
 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 this health benefit plan
 8. That you have not had a domestic partner covered under this health benefit 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[,][or] your spouse’s [or your [same sex] domestic partner’s] DEPENDENT CHILDREN through the end of the month of their 26th birthday.
- A DEPENDENT CHILD who in accordance with North Carolina law, is and continues to be intellectually disabled or physically handicapped and incapable of self-support may continue to be covered under this health benefit plan regardless of age if the condition exists and coverage is in effect when the child reaches the end of eligibility for DEPENDENT CHILDREN. The handicap must be medically certified by the child’s DOCTOR and may be verified annually by BCBSNC.

Enrolling in this Health Benefit Plan

Benefits under this health benefit plan are not subject to any WAITING PERIOD for PRE-EXISTING CONDITIONS (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.

[SGEX→] [If your EMPLOYER chooses to participate in the SHOP, eligibility and effective date determinations for this health benefit plan as well as enrollment, will be handled through the SHOP. BCBSNC will also be coordinating its enrollment activities with the SHOP so that you and any DEPENDENTS are enrolled within the timelines set by the SHOP.

You or your DEPENDENTS may apply for coverage only during the annual enrollment period or a special enrollment period for which you or your DEPENDENTS have been determined to be eligible through SHOP. If you are a new employee and become eligible to participate in the SHOP outside of the annual enrollment period, you may apply for coverage beginning on the date that you are eligible to participate in the SHOP health insurance plan. Unless otherwise noted, special enrollment periods consist of a 30-day period following specified triggering/qualifying events (hereafter referred to as “triggering events”), during which you and/or your DEPENDENTS may enroll in this health benefit plan or change from one health benefit plan to another—outside the annual enrollment period. The EFFECTIVE DATE of coverage will depend on the triggering event.

Provided below, as a convenience, is a list of triggering events, the enrollment period and the EFFECTIVE DATE. This is not meant to be an exhaustive list and may be subject to change by the Federal Government. For a full descriptive list of triggering events and their effective dates, including additional conditions that may apply, see [healthcare.gov].

Triggering Event	Enrollment Period	EFFECTIVE DATE of Coverage
You or your DEPENDENTS lose minimum essential coverage (such as loss of coverage due to: death, divorce, Medicare eligibility, age (in the case of a child), termination of employment or reduction of hours)	[30] Days	If plan selection is made on or before the loss of MEC = 1 st day of the month following loss of coverage. If plan selection is made after the loss of coverage: <ol style="list-style-type: none"> 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You gain a DEPENDENT or become a dependent through birth, adoption, placement for adoption, or placement as a FOSTER CHILD	[30] Days	<ol style="list-style-type: none"> 1. Date of birth, adoption, or placement of adoption, or the date of the placement of a FOSTER CHILD in your home (default option) or 2. First day of the month following birth, adoption, placement for adoption or placement in foster care or 3. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You gain a DEPENDENT or become a dependent through marriage	[30] Days	First day of the month following enrollment
You or your DEPENDENTS gain access to a new health benefit plan as a result of a permanent move (if you have minimum essential coverage for one or more days in the 60 days before your move, unless you are moving from a foreign country or U.S. territory)	[30] Days	If apply between the 1 st – 15 th of the month = First day of the following month. If apply between the 16 th – last day of the month = First day of second following month
You or your DEPENDENTS' enrollment or non-enrollment in another health insurance plan was made as a result of an error, misrepresentation, misrepresentation, misconduct or inaction of an officer, employee or agent of the SHOP or another entity providing enrollment assistance	[30] Days	As required by SHOP
You or your DEPENDENTS demonstrate that the health insurance plan you were previously enrolled in substantially violated material provisions of the contract	[30] Days	If apply between the 1 st – 15 th of the month = First day of the following month. If apply between the 16 th – last day of the month = First day of second following month

You or your DEPENDENTS have demonstrated to SHOP that you are an American Indian	[30] Days	If apply between the 1 st – 15 th of the month = First day of the following month. If apply between the 16 th – last day of the month = First day of second following month
You or your DEPENDENTS have demonstrated to SHOP that you meet other exceptional circumstances	[30] Days	As required by SHOP
You or your DEPENDENTS become eligible for premium assistance under Medicaid or the Children’s Health Insurance Program (CHIP) or lose eligibility for Medicaid or CHIP	[60] Days	If apply between the 1 st – 15 th of the month = First day of the following month. If apply between the 16 th – last day of the month = First day of second following month]
You or your DEPENDENTS lose pregnancy related coverage or medically needy coverage as described in the Social Security Act (such as Medicaid)	[30] Days	If plan selection is made on or before the loss of coverage—first day of the month following loss of coverage. If plan selection is made after the loss of coverage: <ol style="list-style-type: none"> 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – last day of the month = First day of second following month
You or your DEPENDENTS choose not to re-enroll in your non-calendar year group or individual health insurance coverage when the plan renews	[30] Days	If plan selection is made on or before the loss of coverage—first day of the month following loss of coverage. If plan selection is made after the loss of coverage: <ol style="list-style-type: none"> 1. First day of the month following enrollment or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – last day of the month = First day of second following month
You gain a DEPENDENT or become a DEPENDENT via a court order	[30] Days	<ol style="list-style-type: none"> 1. Effective date of court order (default option) or 2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month
You lose a DEPENDENT or DEPENDENT status through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs	[30] Days	If apply between the 1 st – 15 th of the month = First day of the following month. If apply between the 16 th – Last day of the month = First day of Second Following Month
Death of enrollee or their DEPENDENT	[30] Days	<ol style="list-style-type: none"> 1. First day of the month following plan selection

		<p>or</p> <p>2. If apply between the 1st – 15th of the month = First day of the following month. If apply between the 16th – Last day of the month = First day of Second Following Month</p>
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[SGOFF & OE→]

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

See also “Adding or Removing a DEPENDENT.” You may also apply for coverage and/or add DEPENDENTS within a [30][60]-day period following any of the triggering/qualifying events (hereafter referred to as “triggering events”) listed below unless otherwise noted. Coverage is effective no later than the first day of the first month following a completed request for enrollment. The following are considered triggering events:

- You or your DEPENDENTS become eligible for coverage under this health benefit plan
- You get married or obtain a DEPENDENT through birth, court order, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your DEPENDENTS lose coverage under another health benefit plan, and each of the following conditions is met:
 - you and/or your DEPENDENTS are otherwise eligible for coverage under this health benefit plan, and
 - you and/or your DEPENDENTS were covered under another health benefit plan at the time this coverage was previously offered and declined enrollment due to the other coverage, and
 - you and/or your DEPENDENTS lose coverage under another health benefit plan due to i) the exhaustion of the COBRA continuation period, or ii) the loss of eligibility for that coverage for reasons including, but not limited to, divorce, loss of DEPENDENT status, death of the EMPLOYEE, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan’s coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of EMPLOYER contributions toward the cost of the other plan’s coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals
- You or your DEPENDENTS lose coverage due to eligibility under Medicaid or the Children’s Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days
- You or your DEPENDENTS become eligible for premium assistance with respect to coverage under this health benefit plan under Medicaid or the Children’s Health Insurance Program (CHIP) and apply for coverage under this health benefit plan within 60 days.]

[SGOFF→] Adding or Removing a DEPENDENT

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

For coverage to be effective on the [FOM→][first day of the month following the] date the DEPENDENT becomes eligible, your form must be completed within 30 days after the DEPENDENT becomes eligible. However, if you are adding a newborn child, a child legally placed for adoption or a FOSTER CHILD, and adding the DEPENDENT CHILD would not change your coverage type or premiums, the change will be effective on the date the child becomes eligible (the date of birth for a newborn, the date of placement for adoption for adoptive children, or the date of placement of a FOSTER CHILD in your home), as long as coverage was effective on that date. In these cases, notice is

not required by BCBSNC within 30 days after the child becomes eligible, but it is important to provide notification as soon as possible.

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

Qualified Medical Child Support Order

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

Type[FTF→][s] of Coverage

[FTF→] [These are] [This is] the type[FTF→][s] of coverage available:

[FTF→][[Option 01]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[FTF→][[Option 02]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-child coverage—This health benefit plan covers you and one DEPENDENT CHILD
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[FTF→][[Option 03]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-children coverage—This health benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[[Option 04]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-spouse coverage—This health benefit plan covers you and your spouse [or [same sex] domestic partner]
- EMPLOYEE-children coverage—This health benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[FTF→][[Option 05]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-spouse coverage—This health benefit plan covers you and your spouse [or [same sex] domestic partner]
- EMPLOYEE-child coverage—This health benefit plan covers you and one DEPENDENT CHILD
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[FTF→][[Option 06]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-DEPENDENT coverage—This health benefit plan covers you and either your spouse [or [same sex] domestic partner] or one DEPENDENT CHILD
- Family coverage—This health benefit plan covers you and two or more DEPENDENTS which may include your spouse[or [same sex]domestic partner].]

[FTF→][[Option 07]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-spouse coverage—This health benefit plan covers you and your spouse [or [same sex] domestic partner]

- EMPLOYEE-child coverage—This health benefit plan covers you and one DEPENDENT CHILD
- EMPLOYEE-children coverage—This health benefit plan covers you and your DEPENDENT CHILDREN
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

[FTF→][[Option 08]

- EMPLOYEE-only coverage—This health benefit plan covers only you
- EMPLOYEE-spouse coverage—This health benefit plan covers you and your spouse [or [same sex] domestic partner]
- Family coverage—This health benefit plan covers you, your spouse [or [same sex] domestic partner] and your DEPENDENT CHILDREN.]

Reporting Changes

[SGOFF→][Have you moved, added or changed other health coverage, changed your name or phone number? If so, contact your GROUP ADMINISTRATOR and fill out the proper form. It will help us give you better service if BCBSNC is kept informed of these changes.][SGEX→][It is important that you report any changes that may impact your continued enrollment in this health benefit plan to the SHOP. The SHOP is responsible for determining your eligibility and for processing your enrollment in the SHOP. [Visit [healthcare.gov] for more information.]]

Continuing Coverage

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

Medicare

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

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

Continuation Under Federal Law

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

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

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

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

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

Domestic partners and children of the domestic partner are not eligible for COBRA benefits under federal law. All references to DEPENDENTS in this section do not apply to a domestic partner or their children.

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

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

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

- Divorce
- Ineligibility of a DEPENDENT CHILD.

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

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

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

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

[w/ HRA →] [Your continuation rights with respect to your Health Reimbursement Account (HRA) fund are governed by separate documents established by your EMPLOYER and the HRA Administrator. With respect to this health benefit plan administered by BCBSNC, you may choose COBRA continuation as outlined above, even if you have not chosen to continue your HRA fund.]

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

Continuation Under State Law

Under state law, you and your covered DEPENDENTS [(which may include a [same sex] domestic partner and their children)] of any size employer group have the option to continue group coverage for 18 months from the date that you and/or your DEPENDENTS cease to be eligible for coverage under this health benefit plan. You and your DEPENDENTS are not eligible for continuation under state law if:

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

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

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

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

When My Coverage Under This Health Benefit Plan Ends

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

If you or your DEPENDENTS are no longer eligible for coverage under this health benefit plan, you may transfer to individual conversion coverage. For continuous coverage, ensure that your premiums are paid during the continuation period. BCBSNC must be notified within 31 days of loss of eligibility. You must complete an Individual Enrollment Application and pay the applicable premium. Services during the 31-day conversion period will be covered only if the premium is received before the end of the 31-day period. Other options for enrollment in health insurance coverage may be available to you when your coverage in this health benefit plan ends, including, but not limited to, enrollment via the Health Insurance MARKETPLACE.

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

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

Certificate of CREDITABLE COVERAGE

BCBSNC or its designee will supply a Certificate of CREDITABLE COVERAGE when your [or your DEPENDENT'S] coverage under this health benefit plan ends or you exhaust continuation of coverage. Keep the Certificate of CREDITABLE COVERAGE in a safe place. You may request a Certificate of CREDITABLE COVERAGE from BCBSNC Customer Service while you are still covered under this health benefit plan and up to 24 months following your termination. You may call BCBSNC Customer Service at [1-877-258-3334 (toll-free)], Monday through Friday [8:00 a.m. – 9:00 p.m.] except holidays[or visit our website at [website]].

Termination of MEMBER Coverage

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

[SGOFF→][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 this health benefit plan
- No IN-NETWORK PROVIDER is able to establish or maintain a satisfactory DOCTOR-patient relationship with a MEMBER, as determined by BCBSNC
- A MEMBER exhibits disruptive, abusive, or fraudulent behavior toward an IN-NETWORK PROVIDER.

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

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

- Fraud or intentional misrepresentation of a material fact by a MEMBER. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see "Need To Appeal Our 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 health benefit plan, or uses another person's ID CARD.]

[SGEX→][A MEMBER may request termination from this health benefit plan at any time as long as the appropriate notice is given. Visit [healthcare.gov] for information about termination events and notice requirements.

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

- The MEMBER is no longer eligible for coverage in this health benefit plan through the SHOP (termination is effective the last day of the month following the month you provide notice to the SHOP; however, you can request an earlier date. Example: You provide notice on March 15th, your termination date is April 30th);
- The MEMBER changes from one health benefit plan to another during the annual or special enrollment period (termination is effective the day before the start of the new coverage);
- This health benefit plan ends or is no longer allowed to be offered as a health insurance plan in the SHOP. If this health benefit plan is no longer allowed to be offered in the SHOP, BCBSNC may not terminate coverage until the SHOP has notified you and any enrolled DEPENDENTS, and you have had a chance to enroll in another health insurance plan;
- The MEMBER'S coverage is rescinded due to fraud or intentional misrepresentation of a material fact. However, if such termination is made retroactively, including back to the EFFECTIVE DATE of your policy (called a rescission), you will be given 30 days advance written notice of this rescission and may submit an appeal; see "Need To Appeal our Decision?" If your policy is rescinded, any premiums paid will be returned unless BCBSNC deducts the amount for any claims paid;
- The SUBSCRIBER'S EMPLOYER fails to pay premiums;
- The SUBSCRIBER'S EMPLOYER chooses to withdraw from participation in the SHOP.]

UTILIZATION MANAGEMENT

Table of Contents:

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

Key Words:

- ADVERSE BENEFIT DETERMINATION
- MEDICALLY NECESSARY
- CERTIFICATION
- PRIOR REVIEW

To make sure you can have high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires certain health care services to be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, given in the proper setting and for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under this health benefit plan unless the CERTIFICATION was based on:

- A material misrepresentation about your health condition
- You were not eligible for these services under this health benefit plan due to cancellation of coverage (including your voluntary termination of coverage)
- Nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's ADVERSE BENEFIT DETERMINATION of a requested treatment or health care service, along with an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director (doctor licensed in North Carolina) from BCBSNC make a final decision of all NONCERTIFICATIONS Request a review of an ADVERSE BENEFIT DETERMINATION through our appeals process (see "Need To Appeal Our Decision?")
- Have an authorized representative seek payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER'S behalf with the MEMBER'S written consent. In the event you name an authorized representative, "you" under the "UTILIZATION MANAGEMENT" section means "you or your authorized representative". Your representative will also receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Give you and your PROVIDER a toll-free phone number to call UM review staff when CERTIFICATION of a health care service is needed.
- Limit what we ask from you or your PROVIDER to information that is needed to review the service in question
- Ask for all information needed to make the UM decision, including related clinical information
- Give you and your PROVIDER timely notification of the UM decision consistent with applicable state and federal law and this health benefit plan.

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

PRIOR REVIEW (Pre-Service)

Certain services require PRIOR REVIEW as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews. If PRIOR REVIEW is required by BCBSNC, you or your PROVIDER must request PRIOR REVIEW regardless of whether this health benefit plan is your primary or secondary coverage (see "Coordination of Benefits (Overlapping Coverage)"). 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 need PRIOR REVIEW may change from time to time.

General categories of services with this requirement are noted in "COVERED SERVICES." The list of services that require PRIOR REVIEW may change from time to time. For a detailed list of these services and

the most up-to-date information, visit our website at [website] or call BCBSNC Customer Service at the number listed in “Who to Contact?”.

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

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after BCBSNC receives all necessary information. However, it will be no later than 15 days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required. BCBSNC will let you and your PROVIDER know before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will let you and the PROVIDER know of an ADVERSE BENEFIT DETERMINATION electronically or in writing.

Urgent PRIOR REVIEW

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your life, health, or safety or the life, health or safety of others, due to your psychological state; or (ii) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request. BCBSNC will let you and your PROVIDER know of its decision within [72] hours after receiving the request. Your PROVIDER will be notified of the decision, and if the decision results in an ADVERSE BENEFIT DETERMINATION, written notification will be given to you and your PROVIDER.

If BCBSNC needs more information to process your urgent review, BCBSNC will let you and your PROVIDER know of the information needed as soon as possible but no later than 24 hours after we receive your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or within 48 hours after the time period given to the PROVIDER to submit necessary clinical information, whichever comes first.

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

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews. If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting HOSPITAL or other facility within three business days after receipt of all necessary clinical information, but no later than 15 days after we receive the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will let you, your HOSPITAL’S or other facility’S UM department and your PROVIDER know within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Urgent Concurrent Review

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

If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated as soon as possible, but no later than 72 hours after we receive the request.

If BCBSNC needs more information to process your urgent review, BCBSNC will let the requesting HOSPITAL or other facility know of the information needed as soon as possible but no later than 24 hours after we receive the request. The

requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. BCBSNC will make a decision within 48 hours after receipt of the requested information, or within 48 hours after the deadline given to the requesting HOSPITAL or other facility to provide the information, whichever comes first.

Retrospective Reviews (Post-Service)

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

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services.

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

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

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

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for an ongoing special condition at the IN-NETWORK [SEL→][Tier 1] benefit level when you or your EMPLOYER changes health benefit plans or when your PROVIDER is no longer in the [PPO] network. If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition that meets our continuity of care criteria, BCBSNC will notify you in writing [30] days before the PROVIDER'S termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, you must be actively being seen by an OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by BCBSNC's requirements for continuity of care.

An ongoing special condition means:

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

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

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

Continuity of care requests will be reviewed by a medical professional based on the information given about specific medical conditions. If your continuity of care request is denied, you may request a review through our appeals process (see "Need to

Appeal Our Decision?”). Claims for approved continuity of care services will be subject to your IN-NETWORK [SEL→][Tier 1] benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be given when the PROVIDER’S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call BCBSNC Customer Service at the number listed in “Who to Contact?” for more information.

Delegated utilization management

BCBSNC delegates certain UM services for particular benefits to other companies not associated with BCBSNC. Please see [<https://www.bcbsnc.com/content/services/medical-policy/index.htm>] for a detailed list of these companies and benefits. While some benefits have been identified under “COVERED SERVICES,” the list of benefits and/or companies may change from time to time; for the most up-to-date information visit [[bcbsnc.com](https://www.bcbsnc.com)] and search for “Prior Review” for additional information, including those services subject to PRIOR REVIEW and CERTIFICATION.]

NEED TO APPEAL OUR DECISION?

Table of Contents:

- First and Second Level Appeals
- Expedited Appeals
- External Review
- Delegated Appeals

Key Words:

ADVERSE BENEFIT DETERMINATION
GRIEVANCE
MEDICALLY NECESSARY

In addition to the Utilization Management (UM) program, BCBSNC offers a voluntary appeals process for our MEMBERS. An appeal is another review of your case. If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you can request that BCBSNC review the decision or GRIEVANCE.

The process may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you name an authorized representative, "you" under this section means "you or your authorized representative." Your representative will also receive all notices and benefit determinations from the appeal. You may also ask for, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. Mental Health and Substance Abuse as well as Dental appeals have been delegated to third party vendors. Please see the end of this section for contact information. References to BCBSNC throughout this section refer to BCBSNC or the designee.

Steps to Follow in the Appeals Process

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

Any request for review should include:

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

To request a form to submit a request for review, visit our website at [website] or call BCBSNC Customer Service at the number listed in "Who to Contact?"

All information related to a request for a review through BCBSNC's appeals process should be sent to:
[Variable]

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

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

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

After a request for review, a staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case or information before. The denial of the initial claim will not have an effect on the review.

If a claims denial is based on medical judgment, including determinations about whether a certain treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall seek advice from a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC). The health care professionals have not reviewed your case or information before.

You will have exhausted BCBSNC’s internal appeals process after pursuing a first level appeal. Unless specifically noted below, upon completion of the first level appeal you may (1) pursue a second level appeal; (2) pursue an external review; or (3) pursue a civil action under 502(a) of ERISA or under state law, as applicable. You will be deemed to have exhausted BCBSNC’s internal appeals process at any time it is determined that BCBSNC failed to strictly adhere to all claim determinations and appeal requirements under Federal law (other than minor errors that are not likely to cause prejudice or harm to you and were for good cause or a situation beyond BCBSNC’s control). In the event you are deemed to have exhausted BCBSNC’s internal appeals process and, unless specifically noted below, you may pursue items (2) or (3) described above.

Timeline for Appeals

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

	First Level Appeal	Second Level Appeal	Expedited Appeal
BCBSNC Contacts You	Within 3 business days after receipt of request	Within 10 business days after receipt of request	N/A
Notice of Decision	30 days after receipt of request	7 days after the appeal meeting	72 hours after receipt of request-Oral 4 days after receipt of request - Written

First Level Appeal

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

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision.

If your appeal is due to a NONCERTIFICATION, your appeal will be reviewed by a North Carolina licensed medical doctor who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information or rationale that BCBSNC may use in making a decision, so that you may have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

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

Second Level Appeal

Second Level Appeal Timeline

BCBSNC Notifies You	Within 10 business days after receipt of request
Second Level Appeal Meeting	Occurs within 45 days after receipt of request
Notice of the Appeal Meeting	15 days before the appeal meeting
Notice of Decision	7 days after the appeal meeting

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

Otherwise, if you do not agree with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care

complaints. Within ten business days after BCBSNC receives your request for a second level appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and phone number of the appeals coordinator
- Availability of Health Insurance Smart NC including address and phone number
- A statement of your rights, including the right to:
 - request and receive from us all information that applies to your appeal
 - take part in the second level appeal meeting
 - present your case to the review panel
 - submit supporting material before and during the review meeting
 - ask questions of any member of the review panel
 - be assisted or represented by a person of your choosing, including a family MEMBER, an EMPLOYER representative, or an attorney
 - pursue other voluntary alternative dispute resolution options as applicable.

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

Notice of Decision

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

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits upon request at no additional cost.
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision upon request at no additional cost
- 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 this health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided at no additional cost upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment.

You can request an expedited second level review even if you did not request that the initial review be expedited. To start the process of an expedited appeal, you can call BCBSNC Customer Service at the phone number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances. The decision will be communicated no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review (Available only for NONCERTIFICATIONS)

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

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

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

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

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

- completed BCBSNC's first and second level appeals and received a written second level determination from BCBSNC, or
- filed a second level appeal and have not requested or agreed to a delay in the second level appeals process, but have not received BCBSNC's written decision within 60 days of the date you can show that the appeal was filed with BCBSNC, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeal and/or second level appeals process, or
- determined that BCBSNC failed to strictly adhere to all claim determinations and appeal requirements under Federal law (as discussed above).

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

Standard External Review

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

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

Expedited External Review

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

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

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

If your request is not accepted for expedited review, the NCDOI may:

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

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

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

[(Mail)

(In person)

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

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

Tel (toll free): (855) 408-1212

Fax: (919) 807-6865

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

The Health Insurance Smart NC program provides consumer counseling on utilization review and appeals issues.

Within ten business days (or, for an expedited review, within two days) after receipt of your request for an external review, the NCDOI will let you and your PROVIDER know in writing whether your request is complete and whether it has been accepted.

If the NCDOI notifies you that your request is incomplete, you must provide all requested information to the NCDOI within 150 days of the written notice from BCBSNC upholding an ADVERSE BENEFIT DETERMINATION (generally the notice of a second level appeal decision), which initiated your request for an external review.

If the NCDOI accepts your request, the acceptance notice will include the following:

- (i) name and contact information for the IRO assigned to your case;
- (ii) a copy of the information about your case that BCBSNC has provided to the NCDOI; and
- (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial ADVERSE BENEFIT DETERMINATION to the assigned IRO within seven days after the receipt of the notice.

It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC shall provide the IRO and you, by the same or similar quick means of communication, the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION or the second level appeal decision.

If you choose to give any additional information to the IRO, you must also give that same information to BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:

[variable]

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

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within three days) after the date the NCDOI received your external review request. If the IRO's decision is to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will, within three business days (or, for an expedited review, within the same day) after receiving notice of the IRO's decision, reverse the ADVERSE BENEFIT DETERMINATION and provide coverage for the requested service or supply.

If you are no longer covered by BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

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

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and outpatient mental health and substance abuse services to [Vendor Name]. [Vendor Name] is not associated with BCBSNC. Please forward written appeals to:

[Vendor Name]

[Vendor Address (GA)]

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

Quality of Care Complaints

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

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits to Which MEMBERS Are Entitled

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

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under this health benefit plan, and the right to enforce any claim arising under this health benefit plan cannot be transferred or assigned to any other person or entity, including PROVIDERS. PROVIDERS are not considered beneficiaries under this group health plan and do not have standing to sue under ERISA. BCBSNC may pay a PROVIDER directly. For example, BCBSNC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with BCBSNC, and not through this health benefit plan. Under this health benefit plan, BCBSNC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC'S decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under this health benefit plan, including but not limited to benefits, payments or procedures.

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

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

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

BCBSNC will recover amounts we have paid for work-related accidents, injuries, or illnesses covered under state workers' compensation laws upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the EMPLOYER or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

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

BCBSNC'S Disclosure of Protected Health Information (PHI)

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

To obtain a copy of the privacy notice, visit our website at bcbnsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Administrative Discretion

BCBSNC has the authority to use its discretion to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning [SGOFF→][eligibility for benefits,] coverage of services, care, treatment, or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. [SGEX→][Please note that the SHOP has the authority to make eligibility determinations on whether or not you are eligible for benefits.]

Recovery of Overpayment

If a benefit payment is made by BCBSNC to or on your behalf, which exceeds the benefit amount that you are entitled to receive, BCBSNC has the right

- To require return of the overpayment; or
- To reduce the amount of the overpayment by deducting it from any future benefit payment made to or on behalf of you or another person in your family.

The right of recovery of overpayment does not affect any other right of recovery BCBSNC may have with respect to such overpayment. To the extent that BCBSNC is required to bring an action for recovery of an overpayment under this policy, BCBSNC shall be entitled to recover all costs, including attorneys' fees, from you in the prosecution of any action.

The term "overpayment" includes, but is not limited to, any overpayment made to a PROVIDER in relation to treatment provided to you, any mistaken payment, or any payment made on a claim subject to any service or treatment identified as an exclusion in this benefit booklet. The term "overpayment" does not include subrogation of benefits, the right to repayment of the full cost of all benefits provided by BCBSNC on your behalf to the extent you recover from another party.

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 [Product Name] 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 [Product Name] ALLOWED AMOUNT and the contracted amount.

OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

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

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

Whenever you obtain health care services outside the area in which the BCBSNC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between BCBSNC and other Blue Cross and/or Blue Shield licensees. Under the BlueCard Program, the amount you pay toward such COVERED SERVICES, such as deductibles, copayments or coinsurance, is usually based on the **lesser** of:

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

This "negotiated price" can be:

- A simple discount that reflects the actual price paid by the Host Blue to your PROVIDER
- An estimated price that factors in special arrangements with your PROVIDER or with a group of PROVIDERS that may include types of settlements, incentive payments, and/or other credits or charges

- An average price, based on a discount that reflects the expected average savings for similar types of health care PROVIDERS after taking into account the same types of special arrangements as with an estimated price.

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

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

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

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

Value-Based Programs: BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the PROVIDER Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSNC through average pricing or fee schedule adjustments. These fees are part of the total cost of the claim and you will not be charged separately for them. [Additional information available upon request.]

BlueCard Worldwide® Program:

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

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

• Inpatient Services

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

• [Outpatient Services

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

• [Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the PROVIDER'S itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to

initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNC, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.]

Notice of Claim

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

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

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

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

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

Limitation of Actions

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

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

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

Evaluating New Technology

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

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, BCBSNC may take into account benefits paid by the other plan.

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

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

[STD→][Important Information for MEMBERS eligible for Medicare

If you or your DEPENDENTS become eligible for Medicare, you should apply for and enroll in Medicare Part A and Part B, and use PROVIDERS who accept Medicare in order to ensure that you receive full benefit coverage. BCBSNC will assume you have enrolled in Medicare and use PROVIDERS who accept Medicare once eligible for benefits thereunder. If you or your DEPENDENTS are covered under this health benefit plan and are eligible for Medicare, BCBSNC may take into account the benefits that you or your dependent are eligible for under Medicare, regardless of whether you have actually enrolled for such coverage. In other words, even if you have not enrolled in Medicare, BCBSNC may reduce your claim by the benefits that you are eligible for under Medicare, and then pay the remaining claim amount under the terms of this health benefit plan and in accordance with the Medicare secondary payer rules. As a result, your OUT-OF-POCKET costs may be higher if you do not enroll in Medicare.]

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 the provision is	√	
	The plan with the provision 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 and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD’S health care coverage; or	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>	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD'S health care coverage			
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/ separated or not living together 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		√
	<i>Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree*; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.</i>		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	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, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired EMPLOYEE or as that EMPLOYEE'S DEPENDENT is	√	
	The plan that covers a person as a laid-off or retired EMPLOYEE or the DEPENDENT of a laid-off or retired EMPLOYEE is		√
	<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		√

***Note: You may be required to submit a copy of the court order or legal documentation in these instances.**

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

[SPECIAL PROGRAMS

Programs Outside Your Regular Benefits

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

- Discounts or promotional offers on goods and services from other companies including certain types of PROVIDERS
- Health and wellness programs
- 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
- Rewards or drawings for gifts based on participation in initiatives and/or programs to reduce health care costs
- Periodic drawings for gifts, which may include club memberships and trips to special events, based on submitting information
- Charitable donations made on your behalf by BCBSNC.

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

Health Information Services

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

GLOSSARY

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

ADVERSE BENEFIT DETERMINATION

A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit, including one that results from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be EXPERIMENTAL or INVESTIGATIONAL or not MEDICALLY NECESSARY or appropriate. Rescission of coverage is also included as an adverse benefit determination.

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.

ANCILLARY PROVIDER

Independent clinical laboratories, durable/home medical equipment and supply providers, or specialty pharmacies. Ancillary providers are considered IN-NETWORK if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria:

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

BENEFIT PERIOD

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

BENEFIT PERIOD MAXIMUM

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

BIOLOGIC

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

BIOSIMILAR

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

BRAND NAME

The proprietary name of the PRESCRIPTION DRUG that the manufacturer owning the patent places upon a drug product or on its container, label or wrapping at the time of packaging. A brand-name drug has a trade name and is protected by a patent and can only be produced and sold by the manufacturer owning the patent. BCBSNC makes the final determination of the classification of brand-name drug products based on information provided by the manufacturer and other external classification sources, such as the U.S. Food and Drug Administration (FDA) and nationally-recognized drug databases.

CERTIFICATION

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

CLINICALLY NECESSARY (or CLINICAL NECESSITY)

Those COVERED SERVICES, materials or supplies that are:

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

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

CLOSED FORMULARY

A list of prescription medications that are covered under the prescription benefit. PROVIDERS can prescribe from a list of generic and brand medications from each therapeutic category. Medications not on the list must go through a non-formulary exception process for MEDICAL NECESSITY to be reimbursed under the prescription benefit.

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: abruptio of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. EMERGENCY cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL

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

COSMETIC

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

COVERED SERVICE(S)

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

CREDITABLE COVERAGE

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

DENTAL SERVICE(S)

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

DENTIST

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

DEPENDENT

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

DEPENDENT CHILD(REN)

A child, until the end of the month of their 26th birthday, who is either:

- a) a SUBSCRIBER'S biological child, stepchild, legally adopted child (or child placed with the SUBSCRIBER and/or spouse[or [same sex] domestic partner] for adoption), FOSTER CHILD, or
- b) a child for whom legal guardianship has been awarded to the SUBSCRIBER and/or spouse[or [same sex] domestic partner], or
- c) a child for whom the SUBSCRIBER 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.

DOCTOR

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

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL TREATMENT

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

EFFECTIVE DATE

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

EMERGENCY(IES)

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

EMERGENCY SERVICES

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

EMPLOYEE

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

EMPLOYER

The person or organization that you work for and through which this plan is offered.

ERISA

The Employee Retirement Income Security Act of 1974.

ESSENTIAL HEALTH BENEFITS

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

EXPERIMENTAL

See INVESTIGATIONAL.

FACILITY SERVICES

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

FORMULARY

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

FOSTER CHILD(REN)

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

GENERIC

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

GRIEVANCE

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

GROUP ADMINISTRATOR

A representative of the EMPLOYER designated to assist with MEMBER enrollment and provide information to SUBSCRIBERS and MEMBERS concerning this health benefit plan. The Group Administrator is the plan administrator for purposes of ERISA and has the discretionary authority and responsibility to manage and direct the operation of the Plan.

GROUP CONTRACT

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

HABILITATIVE SERVICES

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

HOMEBOUND

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

HOME HEALTH AGENCY

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

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

HOSPICE

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

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

HOSPITAL

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

IDENTIFICATION CARD (ID CARD)

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

INCURRED

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

INFERTILITY

The inability after 12 consecutive months of unsuccessful attempts to conceive a child.

IN-NETWORK

Designated as participating in the [PPO] network. BCBSNC'S payment for in-network COVERED SERVICES [SEL→] depends upon which tier applies to your benefits, and]is described in this benefit booklet as in-network benefits or in-network benefit levels. [SEL→] Tier 1 and Tier 2 PROVIDERS are both considered in-network.]

IN-NETWORK PROVIDER

A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a [Product Name] PROVIDER by BCBSNC or a PROVIDER participating in the BlueCard Program. [SEL→] Tier 1 and Tier 2

PROVIDERS are both considered in-network providers.] ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard program. [SEL→][Services received from PROVIDERS participating in the BlueCard Program will be subject to your IN-NETWORK Tier 1 benefit.]

INVESTIGATIONAL (EXPERIMENTAL)

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

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

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

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

MARKETPLACE

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

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those COVERED SERVICES or supplies that are:

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

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

MEMBER

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

MENTAL ILLNESS

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

NONCERTIFICATION

An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under this health benefit plan has been reviewed and does not meet BCBSNC's requirements for MEDICAL NECESSITY/CLINICAL 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, REHABILITATIVE THERAPY, HABILITATIVE SERVICES and MEDICAL SUPPLIES provided in a PROVIDER'S office.

OTHER PROFESSIONAL PROVIDER

A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES and which is acceptable to BCBSNC. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER

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

OTHER THERAPY (IES)

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

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

OUT-OF-NETWORK

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

OUT-OF-NETWORK PROVIDER

A PROVIDER that has not been designated as a [Product Name] PROVIDER by BCBSNC.

OUTPATIENT CLINIC(S)

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

POSITIONAL PLAGIOCEPHALY

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

PRESCRIPTION

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

PRESCRIPTION DRUG

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

PREVENTIVE CARE

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

PRIMARY CARE PROVIDER (PCP)

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

PRIOR REVIEW

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

PROSTHETIC APPLIANCES

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

PROVIDER

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

PROVIDER-ADMINISTERED SPECIALTY DRUGS

Specialty drugs that are available on the medical benefit typically require close provider supervision and are generally dispensed in an office, outpatient setting, or through an infusion agency.

REGISTERED NURSE (RN)

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

REHABILITATIVE THERAPY

Services and supplies both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote the recovery of the MEMBER from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a

PROVIDER licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

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

RESIDENTIAL TREATMENT FACILITY

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

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.

RESTRICTED-ACCESS DRUGS

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

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

[SGEX→][SHOP

The Small Business Health Options Program Exchange is a new online insurance marketplace run by either the State or Federal Government which permits small employers to shop for and buy qualified health benefit plans.]

SKILLED NURSING FACILITY

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

SPECIALIST

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

SPECIALTY DRUG(S)

Those medications classified by BCBSNC that generally have unique indications or uses, or require special dosing or administration, or are typically prescribed by a SPECIALIST, or are significantly more expensive than alternative therapies. Specialty drugs may be self-administered or provider-administered and classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR.

STABILIZE

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

SUBSCRIBER

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

SURGERY

The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

- a) The correction of fractures and dislocations
- b) Usual and related preoperative and postoperative care
- c) Other procedures as reasonable and approved by BCBSNC.

[COP; SEL→][TIER 1 DRUGS

The PRESCRIPTION DRUG tier which consists of the lowest cost tier of PRESCRIPTION DRUGS, most are GENERIC.

TIER 2 DRUGS

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

TIER 3 DRUGS

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

TIER 4 DRUGS

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

TIER 5 DRUGS

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

TIER 6 DRUGS

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

TOTAL OUT-OF-POCKET LIMIT

The maximum amount listed in "Summary of Benefits" that is payable by the MEMBER in a BENEFIT PERIOD before BCBSNC pays 100% of COVERED SERVICES. It consists of the out-of-pocket expense (which is the annual maximum amount of coinsurance and any copayments) plus the deductible.

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

WAITING PERIOD

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