Quick Reference - Toll Free Phone Numbers, Web Site and Addresses

BCBSNC Web Site *bcbsnc.com*	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site www.bcbsnc.com/memberservices	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility, change your address or request a new ID card.
BCBSNC Customer Service 1-877-258-3334 8 a.m-6 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Certification 1-800-672-7897	To request certification for out-of-network inpatient services.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
Dental Customer Service 1-800-305-6638	For questions about dental benefits and claims inquiries.
Blue Card® PPO Program 1-800-810-BLUE (2583)	To find a participating provider outside of North Carolina.
BCBSNC Health Management Programs 1-800-218-5295	For information about free programs for people who are pregnant or who have asthma, diabetes, congestive heart failure, migraine headaches, multiple sclerosis, rheumatoid arthritis, or other chronic conditions.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Dental Claims Filing: BCBSNC Claims Unit PO Box 2100 Winston Salem, NC 27102-2100	Mail completed dental claims to this address.
Prescription Drug Claims Filing: Medco Health Solutions, Inc. PO Box 14711 Lexington, KY 40512	Mail completed prescription drug claims to this address.
Add/Remove Someone From Your Policy	See your benefit administrator and complete the proper form. For additional questions, call Customer Service at the number listed above.

To see if you are eligible for these services, check your benefits summary in this guide or talk to your benefits administrator.

Quick Reference - Blue Extras℠ - Value-Added Programs

See back of book for full details on each value-added program.

Audio Blue℠ Customer Service
1-877-979-8000 (toll free) or ***bcbsnc.com***
8 a.m.-6 p.m., Monday-Friday, except holidays

For information about discounts on hearing aids.

Blue Points℠ Customer Service
1-888-705-7050 (toll free) or ***bcbsnc.com***
8 a.m.-6 p.m., Monday-Friday, except holidays

For information about our physical activity and wellness incentive program.

Blue Points℠ for Teens Customer Service
1-888-705-7050 (toll free) or ***bcbsnc.com***
8 a.m.-6 p.m., Monday-Friday, except holidays

For information about our physical activity and wellness incentive program for teens ages 13-17.

Blue Points℠ for Kids Customer Service
1-888-705-7050 (toll free) or ***bcbsnc.com***
8 a.m.-6 p.m., Monday-Friday, except holidays

For information about our physical activity and wellness incentive program for kids ages 6-12.

Chiropractic Services Customer Service
Refer to the phone number on your ID card

For information about discounts on chiropractic services.

Get Fit Blue℠
bcbsnc.com

For information about nutrition and weight management discounts.

Health Line Blue℠ Customer Service
1-877-477-2424 (toll free) or ***bcbsnc.com***
24 hours a day, seven days a week

For answers to health questions 24 hours a day from specially trained nurses.

Optic Blue℠ Customer Service
1-800-755-0507 (toll free) or ***bcbsnc.com***
8 a.m.-6 p.m., Monday-Friday, except holidays

For information about discounts on corrective laser eye surgery.

Vita Blue℠
1-888-234-2413 (toll free) or ***bcbsnc.com***
9 a.m.-5 p.m., Monday-Friday, except holidays

For information about discounts on vitamins, minerals and herbal supplements.

To see if you are eligible for these services, talk to your benefits administrator.

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℠ , ® Marks of the Blue Cross and Blue Shield Association

SM1 Service mark of Blue Cross and Blue Shield of North Carolina

Tips for Getting the Most Out of Your Health Care Benefits

1

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a doctor's office is the most cost-effective for you, followed by hospital outpatient services. Hospital inpatient services often bear the highest cost. In addition, remember that in-network care (services from a BCBSNC participating provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. Know what your financial responsibility is before receiving care.

2

Save on prescription drugs

Remind your physician to prescribe generic drugs that provide the same benefit as the brand name counterpart whenever possible. In many cases you will pay a lower drug copayment — sometimes two to three times lower!

3

Pick a primary care physician

While our products do NOT require you to have a primary care physician, we strongly urge you to select and use one. A primary care physician informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary copayments by recommending appropriate specialists, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

4

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site (***bcbsnc.com***), toll free Customer Service lines (1-877-258-3334), and The Blue Book.

5

Take charge of your health and save money through discount programs and other member exclusives

We offer a range of information and programs to help you take charge of your health:

- Audio Blue℠ — Hearing aid discount program
- Blue Points℠ — Physical activity and wellness incentive program
- Blue Points℠ for Teens — Physical activity and wellness incentive program for teens ages 13-17
- Blue Points℠ for Kids — Physical activity and wellness incentive program for kids ages 6-12
- Chiropractic Services— Discounts on chiropractic services
- Get Fit Blue℠ — Nutrition and weight management discount program
- Health Line Blue℠ — 24-hour health information
- Optic Blue℠ — Discounts on corrective laser eye surgery
- Vita Blue℠ — Discounts on vitamins, minerals and herbal supplements
- Special online and print publications

BCBSNC MEMBER RIGHTS AND RESPONSIBILITIES

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

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

As a BCBSNC member, you should:

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

Benefit Booklet
For Employees of
NC Conference of the United Methodist Church
for

Blue OPTIONS℠

Benefit Booklet

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueOptions/008534/2S7O/010110/022210

BENEFIT BOOKLET

This benefit booklet describes the NC Conference of the United Methodist Church *employee* health plan (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

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

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

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

TABLE OF CONTENTS

WELCOME TO BLUE OPTIONS 1

HOW TO USE YOUR BLUE OPTIONS BENEFIT BOOKLET 1

AVISO PARA AFILIADOS QUE NO HABLAN INGLES 1

SUMMARY OF BENEFITS 2

HOW BLUE OPTIONS WORKS 8

OUT-OF-NETWORK BENEFIT EXCEPTIONS 9

CARRY YOUR IDENTIFICATION CARD 9

MAKING AN APPOINTMENT 9

THE ROLE OF A PRIMARY CARE PROVIDER (PCP) OR SPECIALIST 9

HealthLine Blue 10

HOW TO FILE A CLAIM 10

UNDERSTANDING YOUR SHARE OF THE COST 12

COPAYMENTS 12

DEDUCTIBLES 12

COINSURANCE 12

COINSURANCE MAXIMUM 12

COVERED SERVICES 14

OFFICE SERVICES 14

Office Services Exclusions 14

PREVENTIVE CARE 14

Routine Physical Examinations 14

Well-Baby And Well-Child Care 14

Immunizations 15

Routine Eye Exams 15

Gynecological Exam And Cervical Cancer Screening 15

Ovarian Cancer Screening 15

Screening Mammograms 15

Colorectal Screening 16

Prostate Screening 16

DIAGNOSTIC SERVICES 16

Bone Mass Measurement Services 16

EMERGENCY CARE 16

URGENT CARE 19

FAMILY PLANNING 19

Maternity Care 19

Complications Of Pregnancy 20

Infertility Services 20

Sexual Dysfunction Services 20

Sterilization 20

Contraceptive Devices 20

TABLE OF CONTENTS *(cont.)*

Family Planning Exclusions 21
FACILITY SERVICES 21
OTHER SERVICES 21
Ambulance Services 21
Blood 21
Clinical Trials 22
Dental Treatment Covered Under Your Medical Benefit 22
Diabetes-Related Services 23
Durable Medical Equipment 23
Home Health Care 23
Home Infusion Therapy Services 23
Hospice Services 23
Medical Supplies 23
Orthotic Devices 24
Private Duty Nursing 24
Prosthetic Appliances 24
SURGICAL BENEFITS 24
Anesthesia 24
Mastectomy Benefits 25
TEMPOROMANDIBULAR JOINT (TMJ) SERVICES 25
Temporomandibular Joint (TMJ) Services Exclusions 25
THERAPIES 25
Short-Term Rehabilitative Therapies 25
Other Therapies 25
Therapy Exclusions 26
TRANSPLANTS 26
Transplants Exclusions 26
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES 26
Office Visit Services 26
Outpatient Services 27
Inpatient Services 27
How To Access Mental Health And Substance Abuse Services 27
PRESCRIPTION DRUG BENEFITS 27
Three-Tier Benefits 28
Prior Review And Certification For Prescription Drugs 28
Limitations 28
Prescription Drug Benefits Exclusions 29
DENTAL BENEFITS 29
Diagnostic And Preventive Services 29
Basic Services 29
Major Services 30
Orthodontic Services 30
Alternate Course Of Treatment 30
Pre-Treatment Estimate Of Benefits 31

When You File A Claim ... 31
Benefit Limitations ... 31

WHAT IS NOT COVERED? ... 33

WHEN COVERAGE BEGINS AND ENDS ... 36
ENROLLING IN THE PLAN ... 36
Waiting Periods For Pre-existing Conditions ... 36
Timely Enrollees ... 36
Late Enrollees ... 37
ADDING OR REMOVING A DEPENDENT ... 37
QUALIFIED MEDICAL CHILD SUPPORT ORDER ... 37
DENTAL ENROLLMENT ... 37
TYPE OF COVERAGE ... 38
REPORTING CHANGES ... 38
CONTINUING COVERAGE ... 38
Medicare ... 38
Continuation Under Federal Law ... 38
Certificate Of Creditable Coverage ... 39
TERMINATION OF MEMBER COVERAGE ... 39
Termination For Cause ... 39

UTILIZATION MANAGEMENT ... 40
RIGHTS AND RESPONSIBILITIES UNDER THE UM PROGRAM ... 40
PROSPECTIVE REVIEW/PRIOR REVIEW ... 40
Expedited Prospective Review ... 40
CONCURRENT REVIEWS ... 41
Expedited Concurrent Review ... 41
RETROSPECTIVE REVIEWS ... 41
CARE MANAGEMENT ... 41
CONTINUITY OF CARE ... 41
FURTHER REVIEW OF UTILIZATION MANAGEMENT DECISIONS ... 42
DELEGATED UTILIZATION MANAGEMENT ... 42
EVALUATING NEW TECHNOLOGY ... 42

WHAT IF YOU DISAGREE WITH A DECISION? ... 43
STEPS TO FOLLOW IN THE GRIEVANCE PROCESS ... 43
First Level Grievance Review ... 43
Second Level Grievance Review ... 43
Expedited Review ... 44
DELEGATED APPEALS ... 44

ADDITIONAL TERMS OF YOUR COVERAGE ... 45
BENEFITS TO WHICH MEMBERS ARE ENTITLED ... 45
BCBSNC'S DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ... 45

TABLE OF CONTENTS *(cont.)*

ADMINISTRATIVE DISCRETION 45
PROVIDER REIMBURSEMENT 45
Services Received In North Carolina 45
Services Received Outside Of North Carolina 45
RIGHT OF RECOVERY PROVISION 46
NOTICE OF CLAIM 47
LIMITATION OF ACTIONS 47
COORDINATION OF BENEFITS (OVERLAPPING COVERAGE) 47

SPECIAL PROGRAMS 49

GLOSSARY 50

WHOM DO I CALL? 58

WELCOME TO BLUE OPTIONS

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

As a *member* of the Blue Options plan, you will enjoy quality health care from a network of health care *providers* and easy access to *specialists*. You also have the freedom to choose health care *providers* who do not participate in the Blue Options network.

You may receive, upon request, information about Blue Options, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

Please note: This health benefit plan was not specifically designed to be a high *deductible* health plan (HDHP) under the Tax Code, and therefore is not intended to be paired with a health savings account (HSA). Check with a tax advisor to ensure qualification before you pair this health benefit plan with an HSA.

How To Use Your Blue Options Benefit Booklet

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

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

- "Summary Of Benefits" to get an overview of your specific benefits, such as *deductible, coinsurance, copayments* and maximum amounts
- "*Covered Services*" to get more detailed information about what is covered and what is excluded from coverage
- "*Utilization Management*" for important information about when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

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

As you read this benefit booklet, keep in mind that any word you see in **italics (*italics*) is a defined term** and will appear in "Glossary" at the end of this benefit booklet. You will also want to review the following sections of this benefit booklet:

- "How Blue Options Works" explains the coverage levels available to you
- "When Coverage Begins And Ends" tells you, among other things, how and when to enroll in the *Plan*
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Aviso Para *Afiliados* Que No Hablan Ingles

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

SUMMARY OF BENEFITS

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

- Services subject to a *copayment* are not subject to *deductible* and *coinsurance*
- *Copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*
- Services applied to the *deductible* also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*. Please see "*Out-Of-Network* Benefit Exceptions" and *Emergency* Care for additional information. Access to care standards are available on the BCBSNC Web site at bcbsnc.com or by calling BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Call?"**
- If you see an *out-of-network provider,* you will receive *out-of-network* benefits unless otherwise approved by BCBSNC.

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Call?"

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

NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the *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.

Benefit period — January 1, 2010 through December 31, 2010

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

	In-network	*Out-of-network*

Physician Office Services

See *Outpatient* Services for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a combined in- and *out-of-network* maximum of four visits per *benefit period.* Any visits in excess of these *benefit period maximums* are not *covered services*.

	In-network	Out-of-network
***Office Visit* Services**		
Primary Care Provider	$30 *copayment*	60% after *deductible*
Specialist	$40 *copayment*	60% after *deductible*
Includes office *surgery,* x-rays and lab tests.		
CT Scans, MRIs, MRAs and PET Scans	100% after *deductible*	60% after *deductible*
Preventive Care		
Primary Care Provider	$30 *copayment*	**Benefits not available**
Specialist	$40 *copayment*	**Benefits not available**

Includes routine physical exams, well baby, well-child care, and immunizations. **The following *preventive care* benefits are available *out-of-network*: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See "*Covered Services.*"**

	In-network	Out-of-network
Short-term Rehabilitative Therapies	$40 *copayment*	60% after *deductible*
Chiropractic Services	$30 *copayment*	60% after *deductible*

Combined in- and *out-of-network benefit period maximums* apply to home, office and *outpatient* settings. 50 visits per *benefit period* for physical/occupational therapy, including chiropractic services. 30 visits per *benefit period* for speech therapy. Any visits in excess of these *benefit period maximums* are not *covered services.*

	In-network	Out-of-network
Other Therapies	100%	60% after *deductible*

Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient* Services for *other therapies* provided in an *outpatient* setting.

	In-network	Out-of-network
***Infertility* Services**		
Primary Care Provider	$30 *copayment*	60% after *deductible*
Specialist	$40 *copayment*	60% after *deductible*

Combined in- and *out-of-network lifetime maximum* of $5,000 per *member* for *infertility* services, provided in all places of service. Any services in excess of this *lifetime maximum* are not *covered services*.

	In-network	Out-of-network
Routine Eye Exam	$30 *copayment*	**Benefits not available**

	In-network	*Out-of-network*
Urgent Care Centers and Emergency Room		
***Urgent Care* Centers**	$40 *copayment*	$40 *copayment*
Emergency Room Visit	$150 *copayment*	$150 *copayment*

If admitted to the *hospital* from the emergency room, the emergency room *copayment* does not apply; instead, *inpatient hospital* benefits apply to all *covered services* provided in both the emergency room and during *inpatient* hospitalization. If held for observation, the emergency room *copayment* does not apply; instead, *outpatient* benefits apply to all *covered services* provided in both the emergency room and during observation. If you are sent to the emergency room from an *urgent care* center, you may be responsible for both the emergency room *copayment* and the *urgent care copayment*.

	In-network	*Out-of-network*
Ambulatory Surgical Center	100% after *deductible*	60% after *deductible*
***Outpatient* Services**		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*
***Outpatient Clinic* Services**	100% after *deductible*	60% after *deductible*
Therapy Services	100% after *deductible*	60% after *deductible*

Includes *short-term rehabilitative therapies* and *other therapies* including dialysis*;* see Physician Office Services for visit maximums.

	In-network	*Out-of-network*
***Outpatient* Diagnostic Services**		
***Outpatient* lab tests and mammography, when performed alone**	100%	60% after *deductible*
***Outpatient* lab tests and mammography, when performed with another service**		
Physician Services	100%	60% after *deductible*
Hospital and *Hospital*-based Services	100% after *deductible*	60% after *deductible*
***Outpatient* x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests**	100% after *deductible*	60% after *deductible*
CT scans, MRIs, MRAs and PET scans	100% after *deductible*	60% after *deductible*
***Inpatient Hospital* Services**		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*

Includes maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers.*

	In-network	*Out-of-network*
Skilled Nursing Facility	100% after *deductible*	60% after *deductible*

Combined in- and *out-of-network* maximum of 60 days per *benefit period.* Services applied to the *deductible* count towards this day maximum. Any services in excess of these *benefit period maximums* are not *covered services*.

	In-network	*Out-of-network*
Other Services	100% after *deductible*	60% after *deductible*

Includes *ambulance, durable medical equipment, hospice* services, *medical supplies,* orthotic devices, private duty nursing, *prosthetic appliances,* and *home health* care. Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600. Any services in excess of these *benefit periods* or *lifetime maximums* are not *covered services*.

	In-network	*Out-of-network*
Mental Health And Substance Abuse Services		
Mental Health Office Services	$40 *copayment*	60% after *deductible*
Mental Health *Inpatient* Services		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*
Mental Health *Outpatient* Services		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*
Substance Abuse Office Services	$40 *copayment*	60% after *deductible*
Substance Abuse *Inpatient* Services		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*
Substance Abuse *Outpatient* Services		
Physician Services	100% after *deductible*	60% after *deductible*
***Hospital* and *Hospital*-based Services**	100% after *deductible*	60% after *deductible*

Lifetime Maximum, Deductible, and *Coinsurance Maximum*

The following *deductibles* and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

	In-network	*Out-of-network*
Lifetime Maximum	$5,000,000	$5,000,000

Limited to a combined in- and *out-of-network lifetime maximum* per *member.* If you exceed any *lifetime maximum*, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the *provider*'s billed charge.

Deductible		
Individual, per *benefit period*	$750	$1,500
Family, per *benefit period*	$1,500	$3,000

Charges for the following do not apply to the *benefit period deductible:*

- *inpatient* newborn care for well baby
- *prescription drugs*
- *dental services*

Coinsurance Maximum		
Individual, per *benefit period*	$3,000	$6,000
Family, per *benefit period*	$6,000	$12,000

Charges for the following do not apply to the *benefit period coinsurance maximum:*

- *prescription drugs*
- *dental services*

	In-network	*Out-of-network*

Certification **Requirements**

Certain services, regardless of the location, require *prior review* and *certification* by BCBSNC in order to receive benefits. If you go to an *in-network provider* in North Carolina, your *provider* will request *prior review* when necessary. If you go to an *out-of-network provider* in North Carolina or to any *provider* outside of North Carolina, you are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. **Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 25% or a full denial of benefits. See "*Covered Services*" and "Prospective Review/*Prior Review*" in "*Utilization Management*."**

The *Plan* delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. *Prior review* and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* mental health and substance abuse services received from an *in-network provider*, except for *emergencies*. If you choose to receive these services from an *in-network provider* without requesting *prior review* and receiving *certification* from Magellan Behavioral Health, you will receive coverage at the *out-of-network* benefit level and will be responsible for the difference between the *allowed amount* and the *provider's* full charge. Please see the number in "Whom Do I Call?"

Prescription Drugs

	In-network	Out-of-network
***Generic* Drugs** Tier 1	$10 *copayment*	$10 *copayment*, plus the cost of the charges above the *allowed amount*
Preferred *Brand Name* Drugs Tier 2	$30 *copayment*	$30 *copayment,* plus the cost of the charges above the *allowed amount*
***Brand Name* Drugs** Tier 3	$45 *copayment*	$45 *copayment,* plus the cost of the charges above the *allowed amount*
Diabetic Supplies, Spacers and Peak Flow Meters	75%	75%

One *copayment* for up to a 30-day supply. 31-60-day supply is two *copayments*, and 61-90-day supply is three *copayments*. Please refer to "*Prescription Drugs*" in "*Covered Services*" for more information.
Infertility drugs are limited to a combined in- and *out-of-network lifetime maximum* of $5,000 per *member.* Any services in excess of this *lifetime maximum* are not *covered services*.

Additional Benefit Endorsement As Selected by the *Plan Administrator*

Please note: BCBSNC has contracted with certain *providers* for *dental services*. If you receive *dental services* from *providers* who have contracts with BCBSNC, you only pay the *coinsurance* amount and any applicable *deductible* listed below. If you receive *dental services* from *providers* who do not contract with BCBSNC, in addition to the *coinsurance* and any *deductible* listed below, you may be responsible for the difference between the *provider's* actual charge and the *allowed amount*. For a list of *providers* who have contracted with BCBSNC, see the Web site at **bcbsnc.com**.

Dental Blue - Traditional Plan

Benefit period — January 1, 2010 through December 31, 2010

	Benefits
Dental Services	
Diagnostic and Preventive Services	100%
Basic Services	80% after dental *deductible*
Major Services 12-month *waiting period* applies	50% after dental *deductible*
Individual Dental *Deductible* per *benefit period*, includes basic and major services	$50
Family Dental *Deductible* per *benefit period,* includes basic and major services	$150
Benefit Period Maximum per individual, includes diagnostic and preventive, basic and major services	$1,500
Orthodontic Services 12-month *waiting period* applies	50%
Orthodontic *Lifetime Maximum*	$1,000

See "When Coverage Begins And Ends" for information on any applicable *waiting periods*.

HOW BLUE OPTIONS WORKS

Blue Options gives you the freedom to choose any *provider* — the main difference will be the cost to you.

Benefits are available for services from a *provider* that is recognized by BCBSNC as eligible. For a list of eligible *providers*, please visit the Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" Here's a look at how it works:

	In-Network	***Out-of-Network***
Type of *Provider*	*In-network providers* are health care professionals and facilities that have contracted with BCBSNC, or a *provider* participating in the BlueCard® program. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. The list of *in-network providers* may change from time to time. *In-network providers* are listed on the BCBSNC Web site at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"	*Out-of-network providers* are not designated as a Blue Options *provider* by BCBSNC. Also see "*Out-Of-Network* Benefit Exceptions."
Allowed Amount vs. Billed Amount	If the billed amount for *covered services* is greater than the *allowed amount,* you are not responsible for the difference. You pay only the applicable *copayment*, *deductible*, *coinsurance*, and non-covered expenses.	You may be responsible for paying any charges over the *allowed amount* in addition to the applicable *copayment, deductible, coinsurance*, non-covered expenses and *certification* penalty amounts, if any.
Referrals	You are not required to obtain any referrals.	You are not required to obtain any referrals.
Care Outside of North Carolina	Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program, and benefits are provided at the *in-network copayment* or *coinsurance*.	If you are in an area that has participating *providers* and you choose a *provider* outside the network, you will receive the lower *out-of-network* benefit. Also see "*Out-Of-Network* Benefit Exceptions."
Prior Review	*In-network providers* in North Carolina will request *prior review* when necessary. If you receive services outside of North Carolina (even if you see an *in-network provider*), you are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. For *inpatient* or *outpatient* mental health and substance abuse services, either in or outside of North Carolina, contact Magellan Behavioral Health to request *prior review* and receive *certification.*	You are responsible for requesting or ensuring that your *out-of-network provider* requests *prior review* by BCBSNC. Failure to request *prior review* and obtain *certification* may result in a partial or full denial of benefits. *Prior review* is not required for an *emergency* or for an *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section.

	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.	You may have to pay the *out-of-network provider* in full and submit your own claim to BCBSNC; the decision is up to the *out-of-network provider.* Also see "How To File A Claim."

* Note: Some services may not be covered *out-of-network*. Please refer to "Summary Of Benefits" and "*Covered Services.*" For *out-of-network* benefits, you may be required to pay charges over the *allowed amount*, in addition to your *out-of-network deductible* and *coinsurance* amount. In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC. For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **bcbsnc.com**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

Out-Of-Network Benefit Exceptions

In an *emergency,* in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network copayment* or *coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider,* you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **bcbsnc.com**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. Be sure to carry your *ID card* with you at all times and present it each time you seek health care. If any information on your *ID card* is incorrect or if you need additional cards, please visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. Please ask the receptionist if the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. If so, your *medical services* may be covered under *Outpatient* Services benefit and are listed as *Outpatient Clinic* Services in "Summary of Benefits." If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

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

The Role Of A *Primary Care Provider (PCP)* Or *Specialist*

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

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

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

If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "*Utilization Management*."

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

To make this request or if you would like the professional qualifications of your *PCP* or *in-network specialist*, you may call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

HealthLine Blue

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

How To File A Claim

When you file a claim, mail the completed claim form to:

For mental health and substance abuse services:

BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

For *prescription drugs*:

Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

For *dental services*:

BCBSNC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

For all other *medical services*:

BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

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

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

BCBSNC
Customer Services
PO Box 2291

Durham, NC 27702-2291

Copayments

A *copayment* is a fixed dollar amount you must pay for some *covered services*. The *provider* usually collects this amount at the time the service is received. One *copayment* covers most services at a *provider's* office billed with an *office visit*, second surgical opinion, *surgery*, consultation or *short-term rehabilitative therapies*. See "Summary Of Benefits" for your *copayment* amounts.

Copayments also apply to *urgent care* and emergency room services. When you seek these services from an *out-of-network provider*, you may be required to pay the entire bill at the time of service, and file a claim with BCBSNC. You will then be reimbursed the billed amount minus the *copayment*.

Copayments are not credited to the individual or family *coinsurance maximum* or to the *benefit period deductible*.

Deductibles

A *deductible* is the dollar amount you must incur for *covered services* in a *benefit period* before benefits are payable under the *Plan.* If one or more *dependents* are covered under Blue Options, you each have an individual *deductible* and a combined family *deductible*. See "Summary Of Benefits" for your *deductible* amounts.

The *benefit period deductible* does not apply to services where a *copayment* applies.

Note these special rules:

- Charges for the following services do not apply to the *benefit period deductible*:
  - *inpatient* newborn care for well-baby
  - *prescription drugs*
  - *dental services*.
- Amounts applied to your *out-of-network deductible* are credited to your *in-network deductible*
- However, amounts applied to your *in-network deductible* are not credited to your *out-of-network deductible.*

Coinsurance

Coinsurance is the sharing of charges by BCBSNC and the *member* for *covered services*, after you have satisfied your *benefit period deductible*.

Here is an example of what your costs could be for *in-network* or *out-of-network* services. The scenario is a total *outpatient hospital* bill of $5,000.

	In-Network	***Out-of-Network***
A. Total Bill	$5,000	$5,000
B. *Allowed Amount*	$4,250	$4,250
C. *Deductible* Amount	**$250**	**$500**
D. *Allowed Amount* Minus *Deductible* (B-C)	$4,000	$3,750
E. Your *Coinsurance* Amount (x% times D)	**(10%) $400**	**(30%) $1,125**
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)	**$650**	**$2,375**

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

Coinsurance Maximum

The *coinsurance maximum* is the dollar amount of *coinsurance* you pay for *covered services* in a *benefit period* before the *Plan* pays 100% of *covered services.*

Note these special rules:

- Charges for the following services do not apply to the *benefit period coinsurance maximum*:

  - *prescription drugs*
  - *dental services.*
- *Copayments*, *deductibles*, charges over *allowed amounts* and charges for noncovered services are not included in the *coinsurance maximum*
- Charges applied to your *out-of-network coinsurance* are credited to your *in-network coinsurance maximum*
- However, charges applied to your *in-network coinsurance* are not credited to your *out-of-network coinsurance maximum.*

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

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

Office Services

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

The *Plan* also provides benefits for a total of six nutritional counseling visits per *benefit period* to an in- or *out-of-network provider* for those *members* who participate in BCBSNC's Member Health Partnership^{sm} program. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. If you see an *in-network provider* in an office-based setting, any applicable *copayment, coinsurance* or *deductible* is waived for these six visits. If you go to an *out-of-network provider, deductible* and *coinsurance* will apply.

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*.

Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to *coinsurance* and any applicable *deductible*, and may require *prior review* and *certification* or services will not be covered.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. These services are covered as *Outpatient* Services and are listed as *Outpatient Clinic* Services in "Summary Of Benefits."

The *provider* search on the BCBSNC Web site at **bcbsnc.com** indicates which *providers* will collect *deductible* and *coinsurance*, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Office Services Exclusions

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

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy. Some services are only available *in-network* as indicated below.

Routine Physical Examinations

One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age three and older. This benefit is only available *in-network*.

Well-Baby And Well-Child Care

These services are covered for each *member* including periodic assessments and immunizations as recommended by the American Academy of Pediatrics and the United States Preventive Services Task Force. This benefit is only available *in-network*.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered. This benefit is only available *in-network*, except as specifically covered by the *Plan.*

Covered immunizations include the following:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Polio
- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Shingles
- Meningococcal vaccine (available in- and *out-of-network*).
- HiB
- Hepatitis A and B
- Human papillomavirus vaccine
- Chicken pox
- Rotavirus

Immunizations Exclusions

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

Routine Eye Exams

Benefits are only available *in-network*.

Coverage is provided for routine eye exams only when the *provider* is in the Blue Options network. Let the *doctor* know that you are a Blue Options *member* and show your *ID card*. If you need assistance selecting a *doctor* who is a member of this network, you may visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service.

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

Routine Eye Exams Exclusion

- Fitting for contact lenses, glasses or other hardware.

See "Summary Of Benefits" for the following services, since benefits may vary depending on where services are received.

The following benefits are available *in-network* and *out-of-network*:

Gynecological Exam And Cervical Cancer Screening

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

Ovarian Cancer Screening

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

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

Screening Mammograms

The *Plan* provides coverage for one baseline mammogram for any female *member* between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female *member* per calendar year, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female *member* is considered at risk for breast cancer.

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or

- Has not given birth before the age of 30.

Colorectal Screening

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

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

Prostate Screening

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

Diagnostic Services

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

Certain diagnostic imaging procedures, such as CT scans and MRIs, may require *prior review* and *certification* or services will not be covered.

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

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."

Bone Mass Measurement Services

The *Plan* covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

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

Emergency Care

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

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

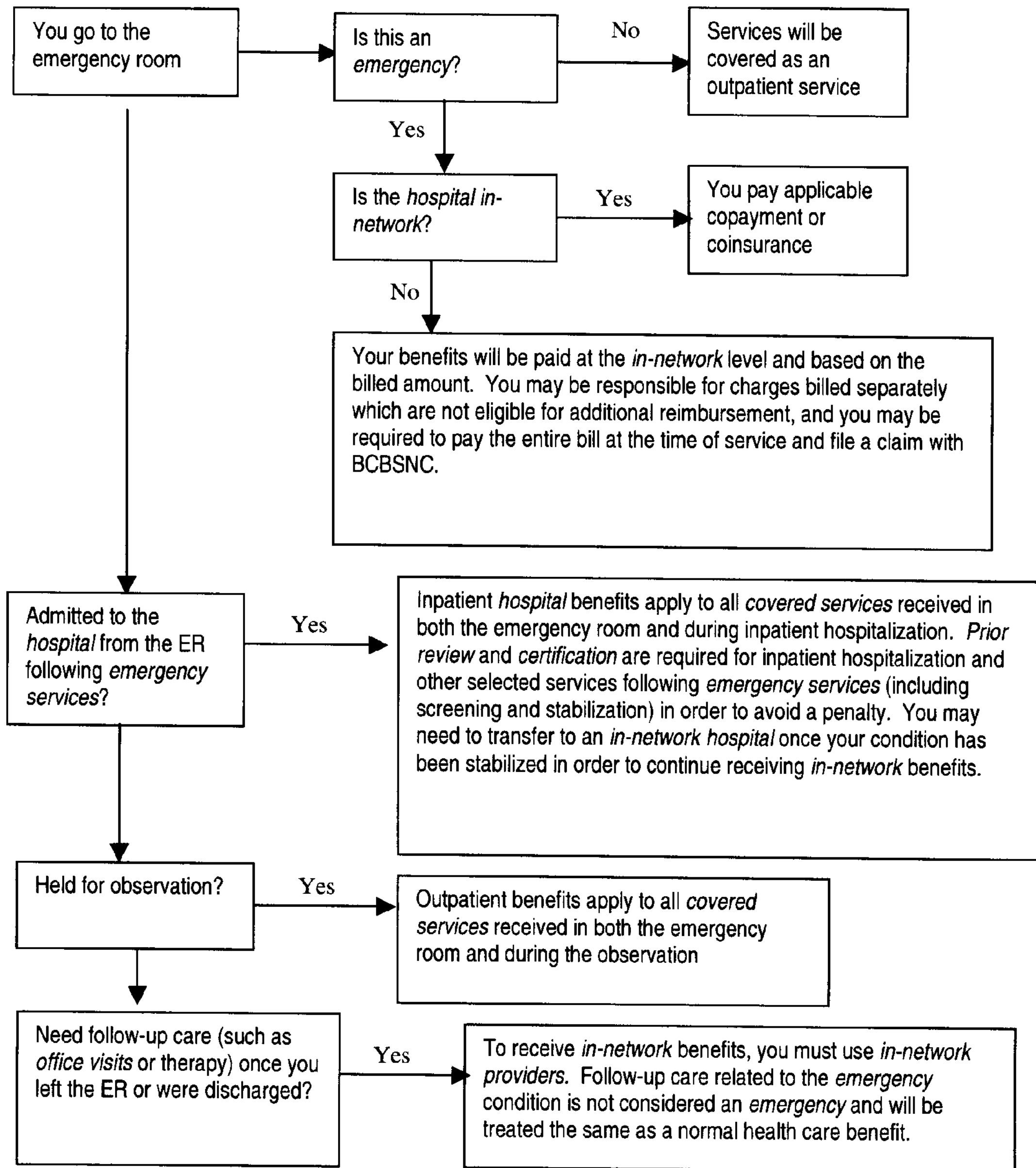
Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of *emergencies.*

What To Do In An *Emergency*

In an *emergency,* you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening *emergencies. Prior review* is not required for *emergency services.* If you are unsure if your

condition is an *emergency,* you can call HealthLine Blue, and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

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



***Urgent* Care**

The *Plan* also provides benefits for *urgent care* services. When you need *urgent care*, call your *PCP*, a *specialist* or go to an *urgent care provider*.If you are not sure if your condition requires *urgent care*, you can call HealthLine Blue.

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

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you left the emergency room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members*. Maternity benefits for *dependent children* cover only treatment for *complications of pregnancy*. A *copayment* may apply for the *office visit* to diagnose pregnancy, otherwise *deductible* and *coinsurance* apply for the remainder of your maternity care benefits. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for pre-natal services depending upon how the services are billed by the *provider*.

	Mom	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		A *copayment* may apply for the *office visit* to diagnose pregnancy. *Deductible* and *coinsurance* apply for the remainder of maternity care benefits.
Labor & delivery services	No *prior review* required for *inpatient hospital* stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge.	No *prior review* required for *inpatient* well baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.	For first 48/96 hours, only one *benefit period deductible* is required for both mother and baby

Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy In order to avoid a penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48/96 hours following a cesarean section	After the first 48/96 hours, whether inpatient (sick baby) or *outpatient* (well baby), the newborn must be enrolled for coverage as a *dependent child*, according to the rules in "When Coverage Begins and Ends." For inpatient services following the first 48/96 hours, *prior review* and *certification* are required in order to avoid a penalty	The baby must meet the individual *benefit period deductible* if applicable

For information on *certification*, contact BCBSNC Customer Service at the number listed in "Whom Do I Call?"

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*.

Termination Of Pregnancy (Abortion)

Benefits for abortion, whether therapeutic or elective, 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* except *dependent children*.

Refer to "Summary Of Benefits" for limitations that may apply.For information about coverage of *infertility prescription drugs*, see "*Prescription Drug* Benefits."

Sexual Dysfunction Services

The *Plan* provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of *sexual dysfunction* for all *members*. Benefits may vary depending on where services are received.

Sterilization

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

Contraceptive Devices

This benefit is available for all *members*. Coverage includes the insertion or removal of and any *medically necessary* examination associated with the use of intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives. See "*Prescription Drug* Benefits" for coverage of oral contraceptives.

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - maternity for *dependent children*
  - termination of pregnancy for *dependent children*
  - reversal of sterilization
  - *infertility* for *dependent children*.
- Elective 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 an *outpatient clinic*
- *Inpatient* services received in a *hospital* or *nonhospital facility*. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. Take home drugs are covered as part of your *prescription drug* benefit. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care" and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Skilled nursing facility* services are limited to a combined in-network and *out-of-network* day maximum per *benefit period*.

Prior review must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty. See "Summary Of Benefits."

Other Services

Ambulance Services

The *Plan* covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility*

when such a facility is the closest one that can provide *covered services* appropriate to your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*.

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Non-emergency air *ambulance* services require *prior review* and *certification* or services will not be covered.

Ambulance Service Exclusion

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

Blood

The *Plan* covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

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

Clinical Trials

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

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

Clinical Trials Exclusions

- Clinical trials phase 1
- Non-health care services, such as services provided for data collection and analysis
- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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

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

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

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

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

In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a *hospital* or *ambulatory surgical* center. This benefit is only available to *dependent children* below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating *provider* must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other *dental* services, including the charge for *surgery*, are not covered unless specifically covered by the *Plan*.

In addition, benefits will be provided if a *member* is treated in a *hospital* following an accidental injury, and *covered services* such as oral *surgery* or reconstructive procedures are required at the same time as treatment for bodily injury.

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:

- 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 Office Services or *Outpatient* Diagnostic Services in the "Summary Of Benefits," depending on where services are received.

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

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

Home Health Care

Home health care services are covered when you need part-time or intermittent skilled nursing care from a *registered nurse (RN)* or *licensed practical nurse (LPN)* and/or other skilled care services like *short-term rehabilitative therapies*. Services may include assistance from a *home health* aide when needed, if you are getting skilled care. These services are covered by the *Plan* when *medically necessary* and when ordered by your *doctor* for a *member* who is *homebound* due to illness or injury. Usually, a *home health agency* coordinates the services your *doctor* orders for you.

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, food or meals.

Medical Supplies

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

To obtain *medical supplies* and equipment, please find a *provider* on the Web site at **bcbsnc.com** or call BCBSNC Customer Service.

Medical Supplies Exclusion

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

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

Orthotic Devices Exclusions

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

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty nursing services of an *RN* or *LPN* when ordered by your *doctor* for a *member* who is receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a *home health agency*.

Private duty nursing requires *prior review* and *certification* or services will not be covered.

These services are always subject to the *deductible* and *coinsurance*, regardless of location of service. See *Care Management*.

Private Duty Nursing Exclusion

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

Prosthetic Appliances

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of *prosthetic appliance* will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract *surgery*. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

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

Surgical Benefits

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

Certain surgical procedures, including those that are potentially *cosmetic*, require *prior review* and *certification* or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please refer to BCBSNC's medical policies, which are on the BCBSNC Web site at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

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

Mastectomy Benefits

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

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas. See Physician Office Services, 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 *deductibles, copayment* or *coinsurance* and limitations as applied to other medical and surgical benefits provided under the *Plan*.

Temporomandibular Joint (TMJ) Services

The *Plan* provides benefits for services provided by a duly licensed *doctor*, *doctor* of dental *surgery*, or *doctor* of dental medicine for diagnostic, therapeutic or surgical procedures, including oral *surgery* involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral *prosthetic appliances* to reposition the bones. Surgical benefits for TMJ disease are limited to *surgery* performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is *medically necessary*. Please have your *provider* contact BCBSNC before receiving surgical treatment for TMJ.

Prior review and *certification* are required for surgical procedures or these services will not be covered, unless treatment is for an *emergency*.

Temporomandibular Joint (TMJ) Services Exclusions

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

Therapies

The *Plan* provides coverage for the following therapy services to promote the recovery of a *member* from an illness, disease or injury when ordered by a *doctor* or *other professional provider.*

Short-Term Rehabilitative Therapies

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

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

Benefits are limited to a combined *in-network* and *out-of-network benefit period* visit maximum for each of these two categories of therapies: (1) occupational and/or physical therapy, or any combination of these therapies; and (2) speech therapy. These visit limits apply in all places of service except *inpatient* (e.g., *outpatient*, office and home) regardless of the type of *provider* (chiropractors, other *doctors,* physical therapists). *Short-term rehabilitative therapy* received while an *inpatient* is not included in the *benefit period maximum.* See "Summary Of Benefits" for additional information.

Other Therapies

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment

- Radiation therapy, including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is *investigational* but will be covered upon *prior review* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.
- Chemotherapy, including intravenous chemotherapy. Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell *transplants,* follow *transplant* guidelines described in "*Transplants*." Also see "*Prescription Drug* Benefits" regarding related covered *prescription drugs*.

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering.

Transplants

The *Plan* provides benefits for *transplants*, including *hospital* and professional services for covered *transplant* procedures. The *Plan* provides care management for *transplant* services and will help you find a Blue Quality Centers for Transplants that must provide the *transplant* services required in order for benefits to be available. Travel and lodging expenses may be reimbursed, based on BCBSNC guidelines that are available upon request from a *transplant* coordinator.

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

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

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

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

Transplants Exclusions

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

Mental Health And Substance Abuse Services

The *Plan* provides benefits for the treatment of *mental illness* and substance abuse by a *hospital*, *doctor* or *other provider*.

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

Office Visit Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules only apply to *mental illness office visits*:

- Each services provided by a mental health *provider* will count as one visit
- Any mental health therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

***Outpatient* Services**

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

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

***Inpatient* Services**

Covered *inpatient* treatment services also include:

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

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services, or for services from an *out-of-network provider* which will be paid at the *out-of-network* benefit level. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your *inpatient* admission as soon as reasonably possible. In addition, if you choose to receive non-emergency *inpatient* or *outpatient* services from an *in-network provider* without requesting *prior review* and receiving *certification* from Magellan Behavioral Health, you will receive coverage at the *out-of-network* benefit level and will be responsible for the difference between the *allowed amount* and the *provider's* full charge. These services are still subject to *medical necessity*.

When you need *inpatient* or *outpatient* treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Call?" The Magellan Behavioral Health customer service representative will refer you to an appropriate *in-network provider* and give you information about *prior review* and *certification* requirements.

Mental Health and Substance Abuse Exclusions and Limitations

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

***Prescription Drug* Benefits**

Your *prescription drug* benefits cover the following:

- *Prescription drugs*, including insulin or other self-administered injectable medications, and contraceptive drugs and devices
- Certain over-the-counter drugs when listed as covered in the *formulary*, and a *provider's prescription* for that drug is presented at the pharmacy
- Spacers for metered dose inhalers and peak flow meters
- *Prescription drugs* related to treatment of *infertility* and *sexual dysfunction*
- *Prescription drugs* approved by the Food and Drug Administration (FDA) for long-term use in the treatment of clinical obesity
- Diabetic supplies such as: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices. Benefits vary for *medical supplies*, depending on whether supplies are received at a *medical supply provider* or at a pharmacy. See "Summary Of Benefits."

Prescription drugs are covered through a network of pharmacies in North Carolina and outside the state. The list of network pharmacies may change from time to time. *In-network* pharmacies are listed on the BCBSNC Web site at **bcbsnc.com**. You may also contact BCBSNC Customer Service at the number listed in "Whom Do I Call?" for information about a specific pharmacy.

Unless otherwise specified under this *Plan*, you may receive your *prescription drugs* and diabetic supplies from any pharmacy. However, your cost will be less if you use an *in-network* pharmacy and present your *ID card* along with your *prescription*. Otherwise, you may be asked to pay the full cost of the *prescription drug* and file a claim. You would then be reimbursed the *allowed amount* less any applicable *coinsurance* or *copayment*. Any charges over the *allowed amount* are your responsibility.

If you have an *emergency* or *urgent care* condition and go to an *out-of-network* pharmacy, the *Plan* recommends that you contact BCBSNC Customer Service at the number listed in "Whom Do I Call?" so that the claim will be processed at the *in-network* level.

Please note that *copayments* for *prescription drugs* are calculated from the national drug code ("NDC") submitted by the pharmacy. If a drug is not available in the dosage prescribed, multiple NDCs may be submitted. Then the *member* is responsible for *copayments* for each 30-day supply for each NDC.

Some *prescription drugs* are only dispensed in 60- or 90-day quantities. For these *prescription drugs* which are subject to a *copayment*, you will pay either two or three *copayments* depending on the quantity you receive.

From time to time, *members* may receive a reduced or waived *copayment* on designated drugs in connection with a program designed to reduce *prescription drug* costs. Please visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" to learn more about these programs and whether or not you may qualify.

You may buy up to a 90-day supply of *prescription drugs* if allowed by your *prescription.* You may have this filled at any pharmacy. If you would like to receive an extended supply of *prescription drugs* through the mail, please have your *provider* write a new *prescription* for up to 90 days, and request a mail order form by selecting the "Find A Drug" tab and then the "Mail order drug program" link at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Please note the following:

- You cannot refill a *prescription* until three-fourths of the supply on hand has been used, except under certain circumstances during a state of emergency or disaster
- *Prescription drug coinsurance* does not apply to the *benefit period coinsurance maximum.*

Three-Tier Benefits

You have an open *formulary* or list of covered *prescription drugs* divided into categories or tiers: *generic* (Tier 1), preferred *brand name* (Tier 2) and *brand name* (Tier 3). BCBSNC determines the tier placement of *prescription drugs* in the *formulary,* and this determines the amount you will pay. The *prescription drugs* listed in the *formulary* or their tier placement may change from time to time.

The chart below explains your benefits:

Tier	Type of Drug	Benefit
Tier 1	*Generic* Drugs	lowest *copayment*
Tier 2	Preferred *Brand Name* Drugs	middle *copayment*
Tier 3	*Brand Name* Drugs	highest *copayment*

If you want to check the tier placement of a drug, please visit the BCBSNC Web site at **bcbsnc.com** and use the "Find a Drug" search tool for the most up-to-date information or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" If you would like a free, printed copy of the *formulary* call BCBSNC Customer Service.

Prior Review And *Certification* For *Prescription Drugs*

Prior review and *certification* by BCBSNC are required for some *prescription drugs* to be covered.

BCBSNC may change the list of these *prescription drugs* from time to time. For a list of *prescription drugs* that require *certification*, visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Limitations

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

Coverage for certain drugs may be subject to a lifetime dollar maximum. See "Summary Of Benefits."

Some *prescription drugs* may be available in limited quantities based on criteria developed by BCBSNC. *Prior review* and *certification* are required before excess quantities of these drugs will be covered.

Some *prescription drugs* may also be subject to supply limits that restrict:

- the amount dispensed per *prescription*, which may include the amount dispensed per day or for a defined time period
- the amount dispensed per lifetime
- the amount dispensed per month's supply
- the amount dispensed per single *copayment.*

In most cases, excess quantities will not be covered; however, if excess quantities are allowed, you may be required to pay an additional *copayment.* You may visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a list of *prescription drugs* subject to quantity limits. This list may change from time to time.

Prescription Drug Benefits Exclusions

Any *prescription drug* that is:

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

Dental Benefits

Your dental benefits provide coverage for the services listed below, which may be obtained from any eligible *provider.* For information about how to enroll for dental coverage, see "When Coverage Begins And Ends."

Diagnostic And Preventive Services

Many dental expenses result from problems that could have been prevented by regular checkups. The *Plan* helps you avoid such expenses by providing benefits for preventive services.

The following are *covered services*:

- Routine oral examinations (twice per *benefit period*)
- Cleaning — prophylaxis, including scaling and polishing above the gum line (twice each *benefit period*)
- X-rays
  - full-mouth or panoramic (limited to once every 36 months unless taken for diagnosis of third molars, cysts, or neoplasms)
  - supplemental bitewings — x-rays showing the back teeth (twice each *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*, covered through age 18)
- Palliative *emergency* treatment for relief of pain only and *emergency* oral examinations, not including permanent restorations or services
- Sealants for first and second permanent molars for *members* age 5 through 15 (one reapplication per tooth every 60 months).

Basic Services

The following are *covered services*:

- Routine fillings to restore diseased teeth
  - amalgam — a soft silver which hardens after it is packed into the cavity
  - composite resin or other tooth-colored filling materials
- 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 *dependents* through age 15)
- Simple extractions
- Oral surgery including surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed for the preparation of the mouth for dentures
- Anesthesia when *clinically necessary* and related to covered surgery
- Periapical x-ray of a tooth
- Stainless steel crowns
- Endodontics — treatment of diseases of the nerve chamber and canals

- pulpotomy — partial removal of a tooth's pulp and placement of medicament
- root canal treatments
- hemisection — dividing the crown and roots of a multi-rooted tooth
- apicoectomy — removing the infected tip of the tooth's root.

Major Services

A *dentist* may use an artificial device to restore natural teeth or treat diseases of the gum and tissues around the teeth. Please note, treatment of crowns, bridges or gold restorations is deemed *incurred* when the tooth is prepared for the procedure.

The following are *covered services*:

- Inlays — not part of a bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Onlays — not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth)
- Full dentures (once every 60 months, no additional allowances for over-dentures or customized dentures)
- Partial dentures (once every 60 months, no additional allowances for precision or semi-precision attachments)
- Fixed bridges (once every 60 months)
- Denture relining done more than six months after the initial insertions (once each *benefit period*)
- Fixed bridge and denture repairs (limited to repairs or adjustments done after 12 months following the initial insertion)
- Recementing of inlays, crowns and/or bridges
- Crowns not part of bridge (once every 60 months, covered only when a filling cannot restore the tooth).

Treatment of the diseases of the gums and bone surrounding the teeth is periodontics. The following are covered periodontal services:

- Gingival curettage — scraping or cleaning the inner gum tissues surrounding the teeth
- Gingivectomy and gingivoplasty — cutting out diseased or overgrown gum tissues around the teeth (once every 36 months per site or quadrant)
- Osseous surgery — removing or reshaping the bone around the teeth through an incision of the gum (once every 36 months per site or quadrant)
- Crown lengthening — reshaping the bone around the teeth to allow for proper prosthetic preparation (once every 36 months per site or quadrant)
- Mucogingivoplastic surgery — reconstructing the gum surface and mucous membrane
- Root planing and periodontal scaling — scraping to remove mineralized deposits and smooth rough, infected root surfaces (once per quadrant every 24 months)
- Periodontal maintenance (twice within 12 months)
- Periodontal exam and consultations (twice each *benefit period*).

Orthodontic Services

Benefits for a comprehensive orthodontic treatment are covered for all eligible *members* through age 18. If you receive orthodontic treatment before your *effective date*, benefits may be available for further orthodontic services as long as you have satisfied any applicable *waiting period*. 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 paid based on the orthodontic treatment plan, consisting of an initial payment no greater than 30 percent of the total charge of the orthodontic treatment plan and monthly payments based on the existing treatment plan. In order for benefits to continue throughout the treatment plan, this *Plan* must remain in effect, the *member* must remain enrolled on the *Plan*, and the *member's lifetime maximum* must not be met.

Alternate Course Of Treatment

In all cases involving services in which either you or your *provider* selects a course of treatment, benefits will be based on the procedures that are consistent with professional standards of dental practice for the dental condition.

Pre-Treatment Estimate Of Benefits

When the charges from a *dentist* for a proposed course of treatment are expected to be over $250, a pre-treatment estimate of benefits is strongly recommended before any services are performed. You or your *dentist* can mail information to BCBSNC for a pre-treatment estimate of benefits. BCBSNC will provide information on the portion of the charges that will be allowed.

This chart lists documentation required for a pre-treatment estimate:

	Single Unit Fixed Restorations	Periodontics	Multiple Unit Fixed Restorations	Endodontics	Oral Surgery	Anesthesia
Description	- Crowns - Build-ups - Post and cores	- Root planing and osseous surgery	- Abutments - Pontics	Conventional endodontics on permanent teeth and retreatments	- Surgical extractions - Impactions	- General - IV sedation
Information Required for Claim Processing	Pre-operative x-ray(s)	- Pre-operative x-rays - Periodontal charting	Pre-operative x-rays (full arch)	Pre- and post-operative x-rays	Pre-operative x-ray(s)	- Type - Duration of agent

Please mail the information to:

BCBSNC
Claims Unit
PO Box 2100
Winston Salem, NC 27102-2100

When You File A Claim

In order to process a claim, BCBSNC may need information and require proof of the condition and treatment of your teeth or mouth. For example, BCBSNC may request your complete dental chart, including:

- Previous dental work
- Itemized bills
- Materials and treatment
- X-rays
- Lab report
- Casts, molds, photographs or study models.

Benefit Limitations

- Hospitalization for any dental procedure
- Dental procedures performed solely for *cosmetic* or aesthetic reasons
- Dental procedures not directly associated with dental disease
- Procedures not performed in a dental setting
- Procedures that are considered to be *experimental*, including pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics
- Placement of dental implants, implant-supported abutments and prostheses and any related services. This includes pharmacological regimens and restorative materials.
- Drugs or medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue
- Treatment of malignant or benign neoplasms, cysts, or other pathology, except for excisional removal. (Hard or soft tissue biopsies of neoplasms, cysts, or hard or soft tissue growths of unknown cellular makeup are not excluded.)
- Treatment of *congenital* malformations of hard or soft tissue, including excision
- Replacement of complete or partial dentures, fixed bridgework or crowns within 60 months of initial or supplemental placement
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral
- Services received or begun prior to the *member's effective date* of coverage, except as specifically covered by the *Plan*
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction

- 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
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO)
- Denture relines for complete or partial conventional dentures are not covered for six months following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures are not covered for six months after insertion of the full or partial denture. After this specified *waiting period*, relines are covered once every 12 months.
- One hard-tissue periodontal surgery and one soft-tissue periodontal surgery per surgical area are covered within a three-year period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
- Osseous grafts, with or without resorbable or nonresorbable Guided Tissue Replacement (GTR), are covered once every 36 months per quadrant or surgical site
- Retreatment of a previous root canal, unless the original root canal has been in place for at least 12 months
- Clinical situations that can be effectively treated by a more cost-effective, clinically acceptable, alternative procedure will be assigned a benefit based on the less costly procedure
- Services for incision and drainage if the involved abscessed tooth is removed on the same date of service
- Full-mouth debridement is limited to once every 36 months
- Occlusal guards for any purpose other than control of habitual grinding
- Placement of fixed bridgework solely for the purpose of achieving periodontal stability
- Any *dental services* not specifically listed as a *covered service*.

WHAT IS NOT COVERED?

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

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

In addition, the *Plan* does not cover the following services, supplies, drugs or charges:

A

Acupuncture and acupressure

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

Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

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

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

Cosmetic services, which include the removal of excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*

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

Custodial care

D

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

Dental services provided in a *hospital*, except as specifically covered by the *Plan*

The following **drugs**:

- Injections by a health care professional of injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- Clomiphene (e.g., Clomid®), menotropins (e.g., Repronex®) or other drugs associated with conception by artificial means
- *Experimental* drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment

of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:

- The National Comprehensive Cancer Network Drugs & Biologics Compendium
- The ThomsonMicromedex DrugDex
- The Elsevier Gold Standard's Clinical Pharmacology
- Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

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

Experimental services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the *Plan*

F

Routine ***foot care*** that is palliative or *cosmetic*

G

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

H

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

Holistic *medicine* services. *Holistic medicine* services are unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any other *provider*.

Hypnosis except when used for control of acute or chronic pain

I

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

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

L

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

M

Services or supplies deemed not ***medically necessary***

N

Services that would not be necessary if a **noncovered service** had not been received, except for *emergency services* in the case of an *emergency*

O

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

P

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

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

R

The following **residential care** services:

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

Respite care, whether in the home or in a facility or *inpatient* setting, except as specifically covered by the *Plan*

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*
- Available to a *member* without charge.

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

Sexual dysfunction unrelated to organic disease

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

T

The following types of **therapy**:

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

Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*

V

The following **vision** services:

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

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

W

Wigs, hair pieces and hair implants for any reason

To be covered under the *Plan,* you must be an active full-time *employee* who works 30 or more hours per week. However, your *employer* may establish additional criteria you must meet before you are eligible for coverage. This may include satisfying a probationary period before your coverage begins.

You may also be eligible for coverage under the *Plan* if the *Plan Administrator* allows eligibility to extend to other persons, such as retirees.

For *dependents* to be covered under the *Plan,* you must be covered and your *dependent* must be one of the following:

- Your spouse, under a legally valid, existing marriage between persons of the opposite sex
- Your or your spouse's unmarried *dependent children* to their 19th birthday, including newborn children from date of birth, stepchildren, adoptive children from date of placement for adoption, *foster children* from date of placement in the foster home, and children for whom health benefit coverage is required under a court or administrative order. Your *employer* may require proof that your *dependent child* meets the eligibility requirements.
- An unmarried *dependent child* who is either mentally retarded or physically handicapped and incapable of self-support may continue to be covered under the *Plan* regardless of age if the condition exists and coverage is in effect when the child reaches the age of 19. The handicap must be medically certified by the child's *doctor* and may be verified annually by BCBSNC.

Enrolling In The *Plan*

It is very important whether you apply for coverage and/or add *dependents* at your first opportunity or delay your application. When you apply for coverage will determine whether you and your *dependents* are timely or late enrollees and the length of any waiting period for *pre-existing conditions.*

Waiting Periods For *Pre-existing Conditions*

You and your *dependents* may have to satisfy a waiting period for *pre-existing conditions* under the *Plan*. Any waiting period for *pre-existing conditions* begins on the enrollment date. For purposes of a *pre-existing condition* waiting period, the enrollment date is the first day of coverage under the *Plan* or the first day of any probationary period, whichever is earlier.

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

For purposes of determining the specifics around any waiting period for *pre-existing conditions,* a "significant break in coverage" is 63 or more consecutive days prior to the enrollment date, during which you have no proof of *creditable coverage*.

Benefits will not be provided for any condition excluded from coverage by the terms of the *Plan*, even after the expiration of the *waiting periods* stated above.

The waiting period for *pre-existing conditions* will be reduced by the number of days you or your *dependents* had prior *creditable coverage,* so long as there was no significant break in coverage. The Certificate of Creditable Coverage or other evidence of *creditable coverage* can be provided as soon as reasonably possible.

Timely Enrollees

Timely enrollees are subject to a 00-month waiting period for *pre-existing conditions.* Newborns, adoptive children, *foster children,* and eligible children who are added as a result of a court order are not subject to a *waiting period.*

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

The following are considered qualifying events:

- You or your *dependents* become eligible for coverage under the *Plan*
- You get married or obtain a *dependent* through birth, adoption, placement in anticipation of adoption, or foster care placement of an eligible child
- You or your *dependents* lose coverage under another health benefit plan, and each of the following conditions is met:
  - you and/or your *dependents* are otherwise eligible for coverage under the *Plan*, and

  - you and/or your *dependents* were covered under another health benefit plan at the time 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, loss of *dependent* status, divorce, death of the member, termination of employment, or reduction in the number of hours of employment, or iii) the termination of the other plan's coverage, or iv) the offered health benefit plan not providing benefits in your service area and no other health benefit plans are available, or v) the termination of employer contributions toward the cost of the other plan's coverage, or vi) meeting or exceeding the lifetime benefit maximum, or vii) the discontinuance of the health benefit plan to similarly situated individuals.
- You or your *dependents* lose coverage due to loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) and apply for coverage under this *Plan* within 60 days
- You or your *dependents* become eligible for premium assistance with respect to coverage under this *Plan* under Medicaid or Children's Health Insurance Program (CHIP).

Late Enrollees

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

Adding Or Removing A *Dependent*

Do you want to add or remove a *dependent*? You must notify the *Plan Administrator* and BCBSNC and complete any required forms. Failure to timely notify the *Plan Administrator* of the need to remove a *dependent* could result in loss of eligibility for continuation of coverage.

For coverage to be effective on the date the *dependent* becomes eligible, the proper form must be completed within 30 days after the *dependent* becomes eligible.

If you are adding a newborn child, a child legally placed for adoption or a *foster child*, and adding the *dependent child* would not change your coverage type or the premiums that are owed, 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), if the birth or date of placement occurs after the coverage is effective. Notice is not required by the *Plan Administrator* within 30 days after the child becomes eligible; however, it is important to provide notification as soon as possible.

You may remove *dependents* from your coverage by contacting the *Plan Administrator* and completing the proper form. *Dependents* must be removed from coverage when they are no longer eligible, such as when a child is no longer eligible due to age, marriage, or when a spouse is no longer eligible due to divorce, legal separation or death.

Qualified Medical Child Support Order

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

Dental Enrollment

Your medical enrollment period does not apply to dental enrollment. You are a timely enrollee if you apply for dental coverage and/or add *dependents* within a 30-day period of when you first become eligible for coverage under this *Plan*, or within 30 days following a qualifying event. Newborns added up to 30 days after their first birthday will have no *waiting period.* Adoptive children, *foster children*, and eligible children who are added as a result of a court order are not subject to a *waiting period.* Once dental coverage has terminated, regardless of the reason, you may not re-enroll, unless a qualifying event occurs.

If you apply for coverage at a time which does not qualify you or your *dependents* as timely enrollees as stated above, then you are considered late enrollees. Late enrollees have no *waiting period* for diagnostic and preventive services. For all other *dental services,* where timely enrollees have no *waiting period,* late enrollees have a 12-month *waiting period.* Where timely enrollees have *waiting periods,* these *waiting periods* are doubled for late enrollees. See *waiting periods* described below.

There is no *waiting period* for *members* to receive benefits for diagnostic and preventive or basic services, except for late enrollees as described above. However, there is a 12-month *waiting period* for major services and a 12-month *waiting period* for orthodontic services. These *waiting periods* are doubled for late enrollees. *Waiting periods* are waived for timely enrollees who can show proof of prior dental coverage. If a *waiting period* applies, see the Dental Coverage chart in "*Covered Services*."

Type Of Coverage

- Employee-only coverage — The *Plan* covers only you
- Family coverage — The *Plan* covers you, your spouse and your *dependent children*.

Reporting Changes

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

Continuing Coverage

Under certain circumstances, your eligibility for coverage under this *Plan* may end. You may have certain options such as enrolling in Medicare or continuing health insurance under this *Plan*.

Medicare

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

If you are covered by this *Plan* when you become eligible for Medicare, consult the *Plan Administrator,* who will advise you about continuation of coverage under the *Plan*.

Continuation Under Federal Law

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

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

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

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

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

If you are a retired *employee* and your *employer* allows coverage to extend to retirees under this *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 the *Plan Administrator* for conditions and duration of continuation coverage.

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

You or your *dependents* must notify the *Plan Administrator* within 60 days of the following qualifying events:

- Divorce

- Legal separation
- Ineligibility of a *dependent child*.

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

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

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

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

If you have any questions about your COBRA rights or continuation of coverage, please contact the *Plan Administrator*.

Certificate Of Creditable Coverage

The *Plan Administrator* or its designee will supply a Certificate of Creditable Coverage when your or your *dependent's* coverage under the *Plan* ends or you exhaust continuation of coverage. Keep the Certificate of Creditable Coverage in a safe place. It may help you receive credit toward any new *pre-existing conditions* waiting period that applies on subsequent coverage. You may request a Certificate of Creditable Coverage from BCBSNC Customer Service while you are still covered under the *Plan* and up to 24 months following your termination.

You may call BCBSNC Customer Service at 1-877-258-3344 (toll-free), Monday through Friday 8:00 a.m. - 6:00 p.m. except holidays.

Termination Of *Member* Coverage

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

Termination For Cause

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

- The *member* fails to pay or to have paid on his or her behalf or to make arrangements to pay any *copayments, deductible* or *coinsurance* for services covered under the *Plan*
- No *in-network provider* is able to establish or maintain a satisfactory *doctor*-patient relationship with a *member*, as determined by the *Plan*
- A *member* exhibits disruptive, abusive, or fraudulent behavior toward an *in-network provider*.

As an alternative to termination as stated above, the *Plan*, in its sole discretion, may limit or revoke a *member's* access to certain *in-network providers*.

A *member's* coverage under the *Plan* will be terminated immediately for the following reasons:

- Fraud or material misrepresentation by the *member* or *dependent*
- A *member* has been convicted of (or a restraining order has been issued for) communicating threats of harm to BCBSNC personnel or property
- A *member* permits the use of his or her or any other *member's ID card* by any other person not enrolled under this *Plan*, or uses another person's *ID card*.

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

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

Under the *UM* program, you have the right to:

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

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

BCBSNC's Responsibilities

As part of all *UM* decisions, BCBSNC will:

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

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

Prospective Review/*Prior Review*

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services.*" These types of reviews are called prospective reviews. If neither you nor your *provider* requests *prior review* and receives *certification,* this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "*Covered Services.*" You may also visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.

If the requested *certification* is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered *out-of-network*. See "*Covered Services.*"

BCBSNC will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your *provider* of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if additional information is needed. BCBSNC will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the *provider* by written or electronic confirmation.

Expedited Prospective Review

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

is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by calling BCBSNC Customer Service at the number given in "Whom Do I Call?"

Concurrent Reviews

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

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

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

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

Retrospective Reviews

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

Care Management

Members with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management) encourages *members* with complicated or chronic medical needs, their *providers*, and the *Plan,* to work together to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The *Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by contacting an *in-network PCP* or *in-network specialist* or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows *members* to continue receiving care from an *out-of-network provider* for ongoing special conditions at the *in-network copayment* or *coinsurance* level when the *member* or *employer* changes plans or when their *provider* is no longer in the Blue Options network. If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the *provider's* termination, as long as BCBSNC receives timely notification from the *provider*. To be eligible for continuity of care, the *member* must be actively being seen by the *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the BCBSNC requirements for continuity of care. An ongoing special condition means:

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

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

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

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

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

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

Evaluating New Technology

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

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members. Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

Steps To Follow In The *Grievance* Process

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

Any request for review should include:

- *Employee's* ID number
- *Employee's* name
- Patient's name
- The nature of the *grievance*
- Any other information that may be helpful for the review.

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

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

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

In addition, *members* may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
Consumer Protection Division, Office of the Attorney General
9001 Mail Service Center
Raleigh, NC 27699-9001
Fax: 1-919-733-6276
Tel: 1-919-733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

First Level *Grievance* Review

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

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

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

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:
  - request and receive from BCBSNC all information that applies to your case from BCBSNC
  - attend the second level *grievance* review meeting
  - present your case to the review panel
  - submit supporting material before and at the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a

full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Expedited Review

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

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

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

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

Delegated Appeals

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

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

Second level *grievance* review is provided by BCBSNC.

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *member.*

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

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan.*

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

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

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

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

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 *provider*. 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* actual charge for *covered services* provided to a *member*.

Services Received In North Carolina

Some *out-of-network providers* have other agreements with BCBSNC that affect their reimbursement for *covered services* provided to Blue Options *members*. These *providers* agree not to bill *members* for any charges higher than their agreed upon, contracted amount. In these situations, *members* will be responsible for the difference between the Blue Options *allowed amount* and the contracted amount. *Out-of-network providers* may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, 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 out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*

- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

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

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

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*; the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

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

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

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

Notice Of Claim

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

Limitation Of Actions

No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the *grievance* process. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred.*

Coordination Of Benefits (Overlapping Coverage)

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

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a coordination of benefits provision. The rules by which a plan is determined primary and secondary are listed below. The "participant" is the person who is signing up for group health insurance coverage.

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

NOTE: The *Plan* pays the difference, if any, between what the *Plan* would have paid and the amount actually paid by the primary plan. If either the primary or the secondary plan covers a particular service, where the *Plan* is the secondary plan, the *Plan* will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the *member* under this *Plan* will be responsible for payment for that service.

BCBSNC may request information about the other plan from the *member*. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for *covered services* under this *Plan* are still subject to program requirements, such as *prior review* and *certification* procedures.

Programs Outside Your Regular Benefits

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

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

These discounts on goods and services may not be provided directly by the *Plan* or BCBSNC, but may instead be arranged for your convenience. These discounts are outside the *Plan* benefits. Neither the *Plan* nor BCBSNC is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside the *Plan* benefits. Neither the *Plan* nor BCBSNC is not liable for third party *providers*' negligent provision of the gifts. The *Plan Administrator* may stop or change these programs at any time.

Health Information Services

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

ALLOWED AMOUNT
The charge that BCBSNC determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and BCBSNC. In the case of *providers* that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the *provider's* actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable *providers* for similar services under a similar health benefit plan. BCBSNC's methodology 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.

AMBULANCE
Transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER
A *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

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

BENEFIT PERIOD
The period of time, as stated in the "Summary Of Benefits," during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan*. A charge shall be considered *incurred* on the date the service or supply was provided to a *member*.

BENEFIT PERIOD MAXIMUM
The maximum amount of charges or number of visits in a *benefit period* that will be covered on behalf of a member. Services in excess of a benefit period maximum are not *covered services* and *members* may be responsible for the entire amount of the *provider's* billed charge.

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

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

COINSURANCE
The sharing of charges by the *Plan* and the *member* for *covered services* received by a *member,* usually stated as a percentage of the *allowed amount*.

COINSURANCE MAXIMUM
The maximum amount of *coinsurance* that a *member* is obligated to pay for *covered services* per *benefit period*.

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

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

COPAYMENT
The fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.

COSMETIC

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

COVERED SERVICE(S)
A service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of the *Plan*. Any services in excess of a *benefit period maximum* or *lifetime maximum* are not covered services.

CREDITABLE COVERAGE
Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE
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.

DEDUCTIBLE
The specified dollar amount for certain *covered services* that the *member* must incur before benefits are payable for the remaining *covered services*. The deductible does not include *copayments, coinsurance,* charges in excess of the *allowed amount,* amounts exceeding any maximum and expenses for noncovered services.

DENTAL SERVICE(S)
Dental care or treatment provided by a *dentist* or *other professional provider* in the *dentist's* office to a covered *member* while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

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

DEPENDENT
A *member* other than the *employee* as specified in "When Coverage Begins And Ends."

DEPENDENT CHILD(REN)
The covered child(ren) of an *employee* or spouse up to the maximum *dependent* age, as specified in "When Coverage Begins And Ends."

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

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

EMPLOYEE
The person who is eligible for coverage under the *Plan* due to employment with the *employer* and who is enrolled for coverage.

EMPLOYER
NC Conference of the United Methodist Church

EXPERIMENTAL
See *Investigational.*

FACILITY SERVICES
Covered services provided and billed by a *hospital* or *nonhospital facility.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

FORMULARY
The list of *outpatient prescription drugs,* insulin, and certain over-the-counter drugs that may be available to *members.*

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

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

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

HOLISTIC MEDICINE
Unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider.*

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

HOME HEALTH AGENCY
A *nonhospital facility* which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:

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

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

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

IDENTIFICATION CARD (ID card)
The card issued to *members* upon enrollment which provides *employer/member* identification numbers, names of the *members,* applicable *copayments* and/or *coinsurance,* and key phone numbers and addresses.

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

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

IN-NETWORK
Designated as participating in the Blue Options network. BCBSNC's payment for in-network *covered services* is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER
A *hospital*, *doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a Blue Options *provider* by BCBSNC or a *provider* participating in the BlueCard program.

INPATIENT
Pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.

INVESTIGATIONAL (EXPERIMENTAL)
The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:
a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

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

LICENSED PRACTICAL NURSE (LPN)
A nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

LIFETIME MAXIMUM
The maximum amount of *covered services* that will be reimbursed on behalf of a *member* while covered under the *Plan*. Services in excess of any lifetime maximum are not *covered services* and *members* may be responsible for the entire amount of the *provider's* billed charge.

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

MEDICAL CARE/SERVICES
Professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)
Those *covered services* or supplies that are:
a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the *Plan*, not for *experimental*, *investigational*, or *cosmetic* purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

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

MEDICALLY NECESSARY LEAVE OF ABSENCE
With respect to a *dependent child*, is defined as a leave of absence or other change in enrollment of such *dependent child* from a licensed or accredited school that: (1) commences while such *dependent child* is suffering from a serious illness or injury; (2) is *medically necessary*; and (3) causes such *dependent child* to lose student status for the purposes of coverage under the *Plan*.

MEMBER
An *employee* or *dependent,* who is currently enrolled in the *Plan* and for whom premium is paid.

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

NONCERTIFICATION
A determination by BCBSNC that a service covered under the *Plan* has been reviewed and does not meet BCBSNC's requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental*, *investigational* or *cosmetic* is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

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

OFFICE VISIT
Medical care, surgery, diagnostic services, *short-term rehabilitative therapy* services and *medical supplies* provided in a *provider's* office.

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

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

OTHER THERAPY(IES)
The following services and supplies, both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.
a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change

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

OUT-OF-NETWORK
Not designated as participating in the Blue Options network, and not certified in advance by BCBSNC to be considered as *in-network*. Payment for out-of-network *covered services* is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

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

OUTPATIENT
Pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient*.

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

PLAN
The *employer* health benefit plan established by NC Conference of the United Methodist Church to provide health benefits for participants.

PLAN ADMINISTRATOR
NC Conference of the United Methodist Church

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

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

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

PRESCRIPTION DRUG
A drug that has been approved by the Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: Federal law prohibits dispensing without *prescription*," or labeled in a similar manner, and is appropriate to be administered without the presence of a medical supervisor. Prescription drugs include:
a) Insulin
b) Self-administered injectable drugs
c) Contraceptive devices
d) Select diabetic supplies: insulin needles, syringes, glucose testing strips, ketone testing strips and tablets, lancets and lancet devices.

PREVENTIVE CARE
Medical services provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.

PRIMARY CARE PROVIDER (PCP)
An *in-network provider* who has been designated by BCBSNC as a PCP.

PRIOR REVIEW
The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in *certification* or *noncertification* of benefits.

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

PROVIDER
A *hospital, nonhospital facility, doctor,* or *other provider,* accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

ROUTINE FOOT CARE

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

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

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

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

SKILLED NURSING FACILITY
A *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

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

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

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

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

TRANSPLANTS
The surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive *surgery* are not considered transplants.

URGENT CARE

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

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

WAITING PERIOD
The amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the *Plan*.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, get *Plan* information, claim forms, health and wellness information, drug *formulary* updates, find a *doctor,* change your address, and request new *ID cards*, visit the BCBSNC Web site: **bcbsnc.com**

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:

BCBSNC Customer Service . . . . 1-877-258-3334 (toll free)

Mental Health And Substance Abuse Services

BCBSNC delegates the administration of these benefits to Magellan Behavioral Health, which is not associated with BCBSNC. You must contact this vendor directly and request *prior review* for *inpatient* and *outpatient* services, except for *office visits* and in *emergencies*. In the case of an *emergency*, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health . . . . 1-800-359-2422 (toll free)

Dental Services

A dedicated unit is available to answer your questions about dental benefits and claims:

BCBSNC Customer Service . . . . 1-800-305-6638 (toll free)

Out Of North Carolina Care

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

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

HealthLine Blue SM

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue . . . . 1-877-477-2424 (toll free)

Prior Review

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

Providers . . . . 1-800-672-7897 (toll free)
Members . . . . 1-877-258-3334 (toll free)

Value-Added Programs

More than just health insurance. Blue Cross and Blue Shield of North Carolina offers Blue Extras[1] to help you take charge of your care and save you money. These innovative programs compliment your health plan and are available at no additional cost. Blue Extras includes discounts, information and more on a variety of health related products, services and topics. Now that's value-added. That's your plan for better health. For more information, visit the Blue Extras section of **bcbsnc.com**.

AUDIOBlue℠
Hearing aid discount program

BluePOINTS℠
Physical activity and wellness incentive program

BluePoints℠ for Teens
Physical activity and wellness incentive program for teens ages 13-17

BluePoints℠ for Kids
Physical activity and wellness incentive program for kids ages 6-12

Chiropractic Services
Discounts on chiropractic services

GETFITBlue℠
Nutrition and weight management

HEALTHLINEBlue℠
24-hour health information

OPTICBlue℠
Discounts on corrective laser eye surgery

VITABlue℠
Discounts on vitamins, minerals and herbal supplements

SM Marks of the Blue Cross and Blue Shield Association.

[1] Not all plans have access to all Blue Extras programs. Please call Blue Cross and Blue Shield of North Carolina (BCBSNC) for details on what programs are available to you. These programs are not covered benefits under your health insurance contract. BCBSNC does not accept claims or reimburse for these goods or services and members are responsible for paying all bills. BCBSNC reserves the right to discontinue or change these programs at any time.

BlueEXTRAS℠

AUDIOBlue℠

Hearing aid discount program

Do you have to ask others to repeat themselves, turn the TV up too loud, or have difficulty hearing in noisy environments? If so, you should have your hearing checked. If a hearing aid is recommended, Audio Blue [1] offers a 25% discount on manufacturers' suggested retail prices or $250 off usual and customary fees, whichever provides greater savings.

To take advantage of the discount, simply schedule a hearing consultation at a participating provider and present your member ID card. There, the health care specialist can give you recommendations on what types of hearing aids will best fit your lifestyle and budget. You'll be able to choose from traditional behind-the-ear models to state of the art digital models that fit completely in the ear canal.

With Audio Blue, when you purchase a hearing aid you'll also get:

- Free hearing aid fittings
- Free follow-up visits for one year
- Free one-year warranties for service, loss or damage
- Free hearing aid cleanings and checks for one year
- Free one-year supply of batteries

For more information about Audio Blue or to find a participating provider, call 1-877-979-8000 (toll free) or visit the Blue Extras℠ section of **bcbsnc.com**.

℠ Marks of the Blue Cross and Blue Shield Association.

[1] Audio Blue is not a covered benefit under your health insurance contract. Blue Cross and Blue Shield of North Carolina (BCBSNC) does not accept claims or reimburse for these services and members are responsible for paying all bills. BCBSNC reserves the right to discontinue or change this program at any time. Certain groups will not be participating in Audio Blue at this time. Call BCBSNC to make sure Audio Blue is a part of your plan.

BluePOINTS℠

Physical activity and wellness incentive program

From healthy eating to physical activity, there are lots of ways to get or stay healthy. We make healthy activity fun with our Blue Points[1] incentive program. It's a fun way to keep track of your healthy activities and actually rewards you for being active!

All you have to do is record your activities in your Blue Points Activity Log and redeem your points for great prizes.

For more information about Blue Points, visit the Rewards & Discounts section of **bcbsnc.com.**

℠ Marks of the Blue Cross and Blue Shield Association.

[1] Blue Cross and Blue Shield of North Carolina (BCBSNC) reserves the right to discontinue or change this program at any time. Due to specific contracts, selected groups will not be participating in Blue Points at this time. Call BCBSNC to see if Blue Points is a part of your health plan.

BluePoints℠ for Teens BluePoints℠ for Kids

Physical activity and wellness incentive program for kids ages 6-12 and teens ages 13-17

Now you can make Blue Points[1] a family affair. Blue Points for Kids is available for children six to 12 years old and Blue Points for Teens is available for teens 13 to 17 years old. We've created a prize section just for kids and teens and it's filled with cool stuff they won't want to miss.

Blue Points for Kids and Teens has wellness activities for children and teenagers. By logging qualifying activities, your child and teen can earn points toward a prize of their choice. To sign your child or teen up, visit the Blue Points section of **bcbsnc.com**. Remember, Blue Points for Kids members must be registered by a parent or guardian.

For more information about Blue Points for Teens or Kids, visit the Rewards & Discounts section of **bcbsnc.com**.

Chiropractic Services

Discounts on chiropractic services

We know that chiropractic care is one of the most popular forms of alternative medicine. And we know that it's important to you. You can receive services from participating practitioners and save up to 25%. There are no forms to fill out and no referrals are necessary. Just flash your BCBSNC ID card to receive your discount.

We're making chiropractic services available to you, as well as continuing to offer a chiropractic covered benefit. Keep reading to find out the best way for you to access your chiropractic care:

Chiropractic services as a covered benefit
Your health insurance coverage may include chiropractic benefits. If it does, you can receive services from a chiropractor for a copayment or coinsurance, like a doctor's visit.

The chiropractic discount is available to you if:

- you have hit your chiropractic covered benefit limit for the year
- your health coverage does not include chiropractic services
- your visit is for a non-covered service, like some adjustments.

℠ Marks of the Blue Cross and Blue Shield Association.

[1] Blue Cross and Blue Shield of North Carolina (BCBSNC) reserves the right to discontinue or change this program at any time. Due to specific contracts, selected groups will not be participating in Blue Points for Kids and Teens at this time. Call BCBSNC to see if Blue Points for Kids and Teens are a part of your health plan.

GETFITBlue℠

Nutrition and weight management

Maintaining a healthy lifestyle requires an approach through both diet and exercise. That's why Get Fit Blue[1] offers discounts on weight management products, programs and services. Let Get Fit Blue help you beat the odds - the healthy way.

Visit Get Fit Blue at **bcbsnc.com** and find:

- Discounts on participating hospital weight management programs
- Discounts on online and in-person weight management programs
- Discounts on scales, heart rate monitors, body fat analyzers, blood pressure monitors and electronic pulse massagers
- Links to other resources that give you discounts on nutrition counseling, personal training, gym memberships and more

For more information about Get Fit Blue, visit the Blue Extras℠ section of **bcbsnc.com**.

℠ Marks of the Blue Cross and Blue Shield Association.

[1] Get Fit Blue is not a covered benefit under your health insurance contract. BCBSNC does not accept claims or reimburse for these services and members are responsible for paying all bills. BCBSNC reserves the right to discontinue or change this program at any time.

HEALTHLINEBlue℠

24-hour health information

Now you can get confidential, up-to-date health information anytime of the day or night. All it takes is one, easy, toll-free call to Health Line Blue. Specially trained nurses are standing by to assist you with almost any medical question, offer support, and help you navigate the health care system. You can also receive free, award-winning videos and brochures on many health topics.

Access to a Health Line Blue nurse is also available on the Web. With our online Dialog Center you can search unbiased, research-based medical information with real-life patient experiences and send secure e-mail to a Health Line Blue nurse. You can also track symptoms and medication and follow online links to health information recommended by your nurse. On the phone and online, there's no simpler way for you to get the information you need to take control of your health today.

For more information about Health Line Blue, call 1-877-477-2424 (toll free) or visit the Health Line Blue Dialog Center in the Blue Extras℠ section of **bcbsnc.com**.

℠ Marks of the Blue Cross and Blue Shield Association. Certain groups will not be participating in Health Line Blue at this time. Call BCBSNC to make sure Health Line Blue is a part of your plan.

OPTICBlue℠

Discounts on corrective laser eye surgery

Blue Cross and Blue Shield of North Carolina is proud to offer you exceptional vision discounts to help you maintain your vision health.

Vision care

You can take advantage of discounts on eye exams[1], frames, lenses and lens options, contact lenses, and even non-prescription sunglasses. Just present your BCBSNC ID card at participating private practice providers or national retail location — such as Sears, Target, Wal-Mart[2] and more — to start enjoying the savings. If you already receive a vision exam as part of your health plan, you can use one of your plan's in-network ophthalmologists for your exam. Then, use a network provider for your eyewear purchases.[3]

Laser eye surgery

Save up to 25% off standard costs or 5% off advertised specials for LASIK vision correction services through Davis Vision, Inc. All surgeries, including LASIK and PRK, are performed by credentialed ophthalmologists and surgeons using the latest technology.*

Mail-order program

Also available through Davis Vision's Lens 1-2-3® [1] mail-order program, you'll enjoy the guaranteed lowest prices on contact lens replacements.[4] Call 1-800-LENS123 (1-800-536-7123) with a current prescription and receive a complimentary starter kit with each order!

Visit bcbsnc.com to find a provider or learn more about your vision discounts.

* Some centers provide a flat fee equating to these discounts levels due to market dynamics.

[1] Discounts for eye exams are available provided there is no medical allowance in your health plan.

[2] At Wal-Mart, members will receive comparable values through their everyday low prices on examinations, frames and contact lenses purchases.

[3] Members may receive an eye exam at one participating location and eyeglasses from a different participating location. Members should verify that their selected provider for eyeglasses accepts a prescription from another provider before receiving services. For continuity of care, Davis Vision recommends all services be provided at a single participating provider location.

[4] Davis Vision, Inc. conducts pricing reviews to ensure that their published prices are competitive. Lens 1-2-3 also conducts special promotions throughout the year that offer additional savings opportunities. To receive a price match, call 1-800-536-7123.

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® [1] Mark of Davis Vision, Inc.

VITA Blue℠

Discounts on vitamins, minerals and herbal supplements

Vitamins. Minerals. Herbal supplements. We know they're an important part of many people's diets and lifestyles. In fact, 83% of U.S. households use these products.[1] That's why we offer Vita Blue,[2] a program that gives you a broad selection of vitamins, minerals and herbal supplements - all with big savings.

Bigger and better than ever, Vita Blue has significantly expanded its inventory. Now, you're sure to find the products that help you, your kids and even your pets thrive. With Vita Blue you'll get:

- Up to 40% off average drug store, retail and mail order prices[3]
- Free standard shipping on orders over $49
- 50% off the second bottle of select products
- A great selection of over 100 supplements

For more information or to place your Vita Blue order, call 1-888-234-2413 (toll free) or visit the Blue Extras[SM] section of **bcbsnc.com**.

[SM] Marks of the Blue Cross and Blue Shield Association.

[1] The Hartman Group, 2001.

[2] Vita Blue is not a covered benefit under your health insurance contract. Blue Cross and Blue Shield of North Carolina (BCBSNC) does not accept claims or reimburse for these services and members are responsible for paying all bills. BCBSNC reserves the right to discontinue or change this program at any time.

[3] BCBSNC market research, April 2000.

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM

COMMERCIAL OPERATIONS / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers.** ***For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME ______ M.I. ______ MEMBER'S LAST NAME ______

MONTH / DAY / YEAR — MEMBER'S DATE OF BIRTH

PREFIX — 9 DIGIT IDENTIFIER — SUFFIX — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)*

At my request, I authorize BCBSNC to disclose Protected Health Information to ***(enter name of person/entity who will receive member's PHI)*:**

FIRST NAME ______ M.I. ______ LAST NAME ______

RELATIONSHIP TO MEMBER: ______

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: **(i)** your subscriber ID number, **(ii)** your date of birth, and **(iii)** subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

- ☐ ALL Information Requested
- ☐ Enrollment Information
- ☐ Benefit Information
- ☐ Premium Payment Information
- ☐ Explanation of Benefits (EOB) Information
- ☐ All Claims Information
- ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: ______
- ☐ Other *(Please List Specific PHI and/or Date Ranges)*: ______

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically five (5) days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here: → MONTH / DAY / YEAR

I would like this authorization to expire on *(enter date)*: MONTH / DAY / YEAR **OR** ☐ **When my policy expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: ______ **Today's Date:** MONTH / DAY / YEAR

If signed by an individual other than the member: ______ *PRINT YOUR FULL NAME*

Describe your authority to act for the member *(e.g., power of attorney, court order, parent of minor child, etc.)*:

______

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO:

Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291 • Durham, NC 27702-2291

NC Conference of the United Methodist Church
008534 PPO1 01/01/2010 02222010

Blue OPTIONS℠

NC Conference of the United Methodist Church

Group Effective Date: January 1, 2010

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