

Medical Plan

The Medical Plan (“Medical Plan” or “Plan”) is part of the Reynolds American Omnibus Welfare Benefits Plan (“Omnibus Plan”). The following document, together with the Overview of Health Plans and the summary of the Prescription Drug Plan, is a Summary Plan Description (“SPD”) as required by the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. This SPD is intended to provide you with a general explanation of your Medical Plan benefits for all regular full-time employees on the U.S. payroll excluding Hawaii employees. Prescription drug benefits are described in a separate document. Throughout this SPD, “RAI” or “Plan Sponsor” refers to Reynolds American Inc., and “Company” refers to your RAI-affiliated employer.

If you are classified as a regular, full-time employee on a U.S. payroll of Reynolds American Inc., RAI Services Company, RAI Innovations Company, RAI International, Inc., R. J. Reynolds Tobacco Company, Reynolds Innovations Inc., Reynolds Finance Company, R. J. Reynolds Vapor Company, Kentucky BioProcessing Inc., Niconovum USA, Inc., Santa Fe Natural Tobacco Company, Inc., or American Snuff Company, LLC, you are eligible for the Medical Plan. If you are not classified as a regular, full-time employee, you are not eligible to participate in the Medical Plan.

For information about the Prescription Drug Plan benefit that you receive when you enroll into a Medical Plan option, refer to the Prescription Drug Plan document.

Please refer to the Overview of Health Plans for information on Cost, Elections, Change in Family Status, Eligibility, Right of Recovery, General Administration, Your ERISA Rights and Plan Administration.

For information about continuing your benefits if coverage ends, please refer to the General Notice of Continuation Coverage Rights Under COBRA.

Hawaii Residents: Medical benefits for Hawaii employees are provided through the HMSA PPO and are not described in this SPD. For additional details on Hawaii medical benefits, refer to the information made available when you were hired or during the most recent Annual Enrollment period, or call 808-948-6111.

Retiree Medical Coverage: If you retire under a Company retirement plan and are eligible to receive retiree health benefits, refer to the Summary Plan Description for your Company’s retiree health plan for information about those benefits.

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Your Benefit Contacts

www.BlueConnectNC.com

For information about your specific benefits, to check claims status, download forms, request new ID cards, or get helpful wellness tips and BCBS discounts.

BCBSNC Customer Service:

877-275-9787
8 a.m. – 9 p.m. Mondays – Fridays, except
holidays

To find a Blue Cross and Blue Shield network doctor outside of North Carolina or the U.S.:

Call 800-810-2583 or visit www.bcbs.com.
(Network Plan: Blue Options)

Prior Review and Certification:

800-672-7897

To file a claim from an out-of-network provider:

BCBSNC Claims Department - Medical
P.O. Box 35
Durham, NC 27702-0035
877-275-9787

To appeal a claim:

BCBSNC Customer Service - Medical Benefits
Claim Appeals
P.O. Box 30055
Durham, NC 27702-3055
877-275-9787

Mental Health - Magellan Behavioral Health:

You must contact Magellan directly and request
Prior Review for inpatient or residential treatment
services, except in emergencies: 800-359-2422

Healthy Outcomes Maternity:

Provides support to female members 18 years of
age and older who are currently pregnant. This
program offers initial and mid-pregnancy
assessments through a health coach, and
additional nurse support via a 24/7 BabyLine®,
which is available through 6 weeks post-delivery.
855-301-2229

Teladoc® - Not affiliated with Blue Cross Blue Shield of North Carolina

Members enrolled in Medical coverage are eligible to use Teladoc®. Teladoc® is an alternative to a traditional physician office visit designed to supplement, not replace, your primary-care physician. It is a convenient option to receive care either by phone or video conference from a U.S. board certified physician under contract with Teladoc® for minor ailments such as the flu, cold, pink eye, ear infection and bronchitis. This option is not intended to be used for recurring, required physician visits or those related to the dispensing or management of maintenance drugs. You'll be referred to your primary-care physician if you have more than three consultations with Teladoc® within 90 days or more than eight consultations in a year.

For 2016, your cost is \$4 a consultation which is equivalent to 10% of the consultation fee with no deductible. You must register before you can use Teladoc®. Register at www.teladoc.com or call 800-835-2362.

Your Medical Plan Options

(excluding Hawaii)

The Medical Plan is administered by Blue Cross and Blue Shield of North Carolina (BCBSNC). Members have access to Blue Cross and Blue Shield (BCBS) providers nationwide through the BCBS Association and the Blue Options network.

As you read this document, please note that many common terms are defined in the “Definitions” section of this document. Also see the Summary of Coverage charts for an overview of medical and prescription drug coverage.

You have two medical options under the Plan depending on where you live.

Your Medical Options	
If you live within the BCBS network area	If you do NOT live within the BCBS network area
High PPO Option Low PPO Option	Out of Area – High PPO Option

About the PPO

The PPO is a BCBSNC-administered network-based program. Within each option (High and Low), two levels of benefits are available whenever you or a family member requires medical care – in-network and out-of-network benefits.

- In-Network Benefits - To receive the highest level of benefits, you and each family member should use providers in the BCBS network, called in-network providers, to provide all of your health care needs. You can find a list of in-network providers on the BCBSNC website at www.bcbsnc.com, or by calling BCBS Customer Service. Since in-network providers may change you should confirm with your provider that they are in the BCBS network. When you use an in-network provider you receive the highest level of benefits and you don't have to fill out a single claim form.
- Out-of-Network Benefits - Plan benefits that you receive from providers outside the BCBS network (out-of-network providers) are termed out-of-network benefits and are reimbursed at a lower level. All out-of-network benefits are subject to annual deductibles and coinsurance, and you or your health care provider will need to submit bills and claim forms in order to be reimbursed by BCBSNC.

REMEMBER: If you use an out-of-network provider, BCBSNC may send payment for covered services to you and you will be responsible for paying the provider. Do not pay an out-of-network provider until you receive your “Explanation of Benefits” or EOB Form from BCBS to ensure all discounts have been applied. Remember that if you use an out-of-network provider you may be responsible for paying any charges over the allowed amount in addition to the applicable deductible and coinsurance.

You may choose to see an in-network provider or an out-of-network provider each time you seek medical care.

The BCBS Network

The PPO is part of the Blue Options network. With the Blue Options network plan, you enjoy quality health care from a network of health care providers and easy access to specialists. Blue Options gives you access to in-network providers - health care professionals and facilities that have contracted with BCBSNC, or a provider participating in the BlueCard® program. Ancillary providers outside North Carolina are considered in-network only if they contract directly with the Blue Cross and Blue Shield plan in the state where services are provided, even if they participate in the BlueCard® program. See the “Definitions” section for a description of ancillary providers and the criteria for determining where services are received.

Your ID card also gives you access to participating providers outside the state of North Carolina through the BlueCard program, and benefits are provided at the in-network benefit level.

All in-network providers in North Carolina and some outside North Carolina are responsible for requesting prior review when necessary.

Although the BCBSNC network is nationwide, there will be a few situations where members will not have reasonable geographic access to in-network providers and facilities.

In an emergency, in situations where in-network providers are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, out-of-network benefits will be paid at your in-network benefit level. However, you may be responsible for charges billed separately by the provider which are not eligible for additional reimbursement. If you are billed by the provider, you will be responsible for filing a claim with BCBSNC and paying the provider. For information about BCBSNC's access to care standards, see the BCBSNC website at www.bcbsnc.com and type "access to care" in the search bar. If you believe an in-network provider is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an out-of-network provider.

If You Don't Live in a BCBS Network Area

The Out of Area PPO option is only available if you do not live in a BCBS network area. Since the BCBS network is nationwide, eligibility for the Out of Area PPO will be rare.

Benefits levels are not based on whether you use in-network providers or out-of-network providers. However, if you use an in-network provider, you will not have to file claim forms and your out-of-pocket expense may be lower, since in-network providers charge lower negotiated fees.

Throughout this document, you will see references to differing benefit levels for in-network providers compared to out-of-network providers. Generally, these differences do not apply to the Out of Area PPO.

Medical Plan Terms You Need to Know

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

Allowed Amount

The allowed amount is the maximum amount that BCBSNC determines is reasonable for covered services provided to a member. The allowed amount includes any BCBSNC payment to the provider, plus any deductible, coinsurance or copayment. For providers that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the provider has agreed to accept as payment in full. Except as otherwise specified in the "Emergency and Urgent Care" section for providers that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the provider's billed charge or an amount based on an out-of-network fee schedule established by BCBSNC that is applied to comparable providers for similar services under a similar health benefit plan. Where BCBSNC has not established an out-of-network fee schedule amount for the billed service, the allowed amount will be the lesser of the provider's billed charge or a charge established by BCBSNC using a methodology that is applied to comparable providers who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

Coinsurance

Most services are subject to coinsurance. Coinsurance is a percentage of the covered charge, after any applicable deductible is met. See the Summary of Coverage charts for coinsurance amounts.

Coinsurance does not include your deductible, charges over allowed amounts, and charges for ineligible expenses.

Deductible

An annual deductible must be satisfied before the Plan begins to pay for certain covered charges. The amount of deductible you pay depends on which option you elect (High PPO or Low PPO) and whether you use in-network providers or out-of-network providers. You are responsible for all expenses you have for

covered charges during a calendar year up to the amount of your deductible. The Plan then pays the applicable percentage or portion of covered services above that amount, called coinsurance.

The deductible applies to each covered family member separately; however, a family deductible applies to the High options. Under the High options, if you have coverage for more than three individuals, you can meet the deductible as a family, versus each person having to meet the individual deductible. Any covered services which satisfied any part of the year's deductible while you were covered under another medical plan of the Company or a medical plan of an affiliated company will count toward this Plan's deductible for the same year. Deductibles may only be satisfied by expenses of the same category (i.e. in-network or out-of-network). Deductibles are tracked separately for in-network and out-of-network and must be met independently.

The deductible does not include your coinsurance, charges in excess of the allowed amount, charges for ineligible expenses or amounts exceeding any maximum charges.

See the Summary of Coverage charts for the applicable deductible amounts.

There is no deductible for prescription drugs, routine preventive care or PCP in-network visits.

Out-Of-Pocket Limit

The annual out-of-pocket maximum is designed to protect you and your family from severe economic loss due to very large medical expenses in a single year. The out-of-pocket maximum includes the deductible and coinsurance you pay under the Plan. The following are some examples of expenses which cannot be applied to meet the out-of-pocket maximum:

- any expenses over the allowed amount;
- expenses for services received in excess of the Plan maximums;
- charges for ineligible expenses;
- premiums; or
- any additional costs you have to pay because of failure to comply with prior review and certification provisions;

The out-of-pocket maximum applies to each covered family member separately; however, a family out-of-pocket maximum applies to the High Options and in-network benefits under the Low PPO Option. Through the family out-of-pocket maximum, you can meet the out-of-pocket maximum as a family, versus each person having to meet the individual out-of-pocket maximum.

As shown in the Summary of Coverage charts, the amount of the out-of-pocket maximum for each covered individual depends on the option you elect and whether you use in-network providers or out-of-network providers.

Effective January 1, 2015, your annual out-of-pocket maximum also includes costs you pay under the prescription drug program.

Once you or a covered dependent reach the out-of-pocket maximum, any additional coinsurance for that individual is paid by the Plan in full for the rest of the calendar year.

Eligible expenses applied to an individual's out-of-pocket maximum while covered under another medical plan of the Company or a medical plan of an affiliated company will count toward the out-of-pocket maximum for the same year.

Covered Services

Covered services include medical, vision or hearing services and supplies, as well as prescription drug expenses. Covered services for medical, vision and hearing, covered under the Medical Plan, are described in this summary. See the Prescription Drug Plan document for details about prescription drug coverage.

Details on the covered services for medical, vision and hearing services and supplies are provided in the following sections:

- physician services;
- inpatient hospital expenses;
- alternatives to hospital stays;

- outpatient hospital expenses;
- emergency and urgent care;
- preventive care expenses;
- routine physical exam expenses;
- routine cancer screenings;
- routine eye exam expenses;
- routine hearing exam expenses;
- skilled nursing care expenses;
- skilled nursing facility expenses;
- home health care expenses;
- hospice care;
- rehabilitative and habilitative therapy expenses;
- specialized care;
- obesity treatment;
- oral and maxillofacial surgery (mouth, jaws and teeth);
- plastic and reconstructive surgery;
- durable medical equipment and prosthetic appliances;
- diabetic equipment, supplies and education;
- diagnostic and pre-operative testing;
- family planning services;
- acupuncture/acupressure therapy;
- ambulance service;
- clinical trials
- other covered services;
- transplants;
- spine surgery;
- mental health/substance abuse benefits; and
- women's preventive services.

Physician Services

Physician Visits

Covered services include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered services also include:

- immunizations for infectious disease, but not if solely for your employment;
- allergy testing, treatment and injections; and
- charges made by the physician for supplies, radiological services, x-rays, and tests provided by the physician.

Surgery

Covered services include charges made by a physician for:

- performing your surgical procedure;
- pre-operative and post-operative visits; and
- consultation with another physician to obtain a second opinion prior to the surgery.

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, contact BCBSNC Customer Service.

Anesthetics

Covered services include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Walk-In Clinic Visits

Covered services include charges made by walk-in clinics for unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license. For office visits for a routine exam or screening, please see the "Routine Physical Exam Expenses" section.

Inpatient Hospital Expenses

Inpatient hospital expenses are charges made by a hospital for room and board and other hospital services and supplies to a person who is confined as a full-time inpatient, such as:

- physicians and surgeons, if billed by the hospital;
- operating and recovery rooms;
- intensive or special care facilities;
- administration of blood and blood products;
- radiation therapy;
- speech therapy, physical therapy and occupational therapy;
- oxygen and oxygen therapy;
- radiological services, laboratory testing and diagnostic services;
- medications;
- intravenous (IV) preparations; and
- discharge planning.

For admissions related to mental health or substance abuse, see the "Mental Health/Substance Abuse Benefits" section.

Prior review must be requested and certification must be obtained in advance from BCBSNC for hospital admissions to avoid a penalty, except for maternity deliveries and emergencies. Refer to the "Prior Review (Pre-Service)" section under "Utilization Management" for additional information.

The Plan will only pay for nursing services provided by the hospital as part of its charge.

In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay. Covered services for these charges are payable at the out-of-network benefit level if the provider has not contracted with BCBSNC, even if the facility is in the PPO Network.

Maternity-Related Charges

The Plan considers maternity-related charges the same as an illness; therefore, covered hospital charges incurred on account of pregnancy are payable. The Plan may not, under federal law, require that a provider obtain prior review and certification from the Plan for prescribing a length of hospital stay not in excess of 48 hours after vaginal delivery or 96 hours after delivery by Cesarean section. For the first 48 hours (96 hours for a Cesarean section), only one benefit period deductible is required for both mother and baby.

Mothers choosing a stay shorter than 48 hours (or shorter than 96 hours for a Cesarean section) are eligible for a home health visit for post-delivery follow-up care if received within 72 hours after discharge.

Prior review and certification are required for inpatient stays extending beyond 48 hours after vaginal delivery or 96 hours after delivery by Cesarean section.

If the newborn must remain in the hospital beyond the mother's prescribed length of stay for any reason, the newborn is considered a sick baby and these charges are subject to the benefit period deductible if the newborn is added and covered under the Plan.

The Newborns' and Mothers' Health Protection Act of 1996 provides protections on the length of time mothers and their newborn infants may stay in the hospital following childbirth. Generally, group health plans and health insurers may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (or 96 hours following a Cesarean section). The law includes an exception, however, that allows an attending provider, in consultation with the mother, to authorize an earlier discharge. To ensure that the exception does not result in early discharges that might harm the health of the mother or newborn, a group health plan or health insurer may not reduce the compensation of the attending providers because they provide care to a covered individual in accordance with the Act, nor provide incentives to induce the attending providers to provide care in a manner inconsistent with the Act.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered services include charges for services and supplies furnished in connection with outpatient surgery made by:

- a physician or dentist for professional services;
- a surgery center; or
- the outpatient department of a hospital.

The surgery must meet the following requirements:

- the surgery can be performed adequately and safely only in a surgery center or hospital; and
- the surgery is not normally performed in a physician's or dentist's office.

The following outpatient surgery expenses are covered:

- services and supplies provided by the hospital or surgery center on the day of the procedure;
- the operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Charges not covered under this section are:

- the services of a physician or other health care provider who renders technical assistance to the operating physician, including assistant surgeons under some circumstances;
- a stay in a hospital; and
- facility charges for office-based surgery.

Certain surgical procedures, including those that are potentially cosmetic, require prior review and certification or services will not be covered. For more information about specific surgical services or benefits, contact BCBSNC customer service for details.

Birthing Center

Covered services include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- prenatal care;
- delivery; and
- postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Outpatient Hospital Expenses

Covered services include hospital charges for covered services and supplies provided by the outpatient department of a hospital.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside BCBSNC's network area, for:

- an emergency medical condition; or
- an urgent condition.

In Case of a Medical Emergency

An emergency is a recent and severe condition, sickness, or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- death;
- placing your health in serious jeopardy;
- serious impairment to a bodily function(s);
- serious dysfunction to a body part(s) or organ(s); or
- in the case of a pregnant woman, serious jeopardy to the health of the unborn child or the pregnant woman.

When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician (provided a delay would not be detrimental to your health).
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.

Prior review and certification are not required for emergency care. If you go to an out-of-network hospital emergency room, benefits will be paid at the in-network benefit level. However, you may be responsible for charges billed separately which are not eligible for additional reimbursement. You may be required to pay the entire bill and file a claim.

Outpatient benefits apply to all covered services received in an emergency room and during observation.

Coverage for Emergency Medical Conditions

The Plan will pay for hospital services provided in an emergency room to evaluate and treat an emergency medical condition. The emergency care benefit covers:

- use of emergency room facilities;
- emergency room physician services;
- hospital nursing staff services; and
- radiologist and pathologist services.

Please contact your physician after receiving treatment for an emergency medical condition.

In Case of an Urgent Condition

An urgent condition is a sudden illness, injury or condition that:

- requires prompt medical attention to avoid serious deterioration of your health;
- cannot be adequately managed without urgent care or treatment;
- does not require the level of care provided in a hospital emergency room; and
- requires immediate outpatient medical care that cannot wait for your physician to become available.

Call your physician if you think you need urgent care. Physicians usually provide coverage 24 hours a day, including weekends and holidays for urgent care. If you cannot reach your physician, you may contact any physician or urgent care provider for an urgent condition.

If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. If you need help finding an urgent care provider, call BCBSNC Customer Service or you may access BCBSNC's online provider directory at www.bcbsnc.com.

Coverage for an Urgent Condition

The Plan will pay for the services of an urgent care provider to evaluate and treat an urgent condition. Your coverage includes:

- use of urgent care facilities;
- physician services;
- nursing services; and
- staff radiologist and pathologist services.

Please contact your physician after receiving treatment for an urgent medical condition.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care. For coverage purposes, follow-up care is treated as an expense for illness or injury. If you access a hospital emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to the Summary of Coverage charts for coverage levels.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a physician. You may use any provider for your follow-up care. If you use an out-of-network provider, you will be subject to the deductible and coinsurance that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Preventive Care Expenses

Under federal law, you can receive certain covered preventive care services from an in-network provider in an office-based, outpatient, ambulatory surgical setting, or urgent care center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by federal regulations as being eligible. Services, such as diagnostic lab tests, that may be delivered with a preventive care service are not considered preventive care. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your in-network benefit level for the location where services are received. In addition, if a particular preventive care service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided, the Plan may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.

Please visit the BCBSNC website at www.bcbsnc.com/preventive or call BCBSNC Customer Service for the most up-to-date information on preventive care that is covered under federal law, including any limitations that may apply.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you or a covered dependent may be included as covered services. A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:

- x-rays, laboratory and other tests given in connection with the exam;
- immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services Center for Disease Control; and
- testing for tuberculosis.

For a Dependent Child:

To qualify as a covered physical exam, the physician's exam must include at least:

- a review and written record of the patient's complete medical history;
 - a check of all body systems; and
 - a review and discussion of the exam results with the patient or with the parent or guardian.
- For all exams given to your child under age seven, covered services will include charges for routine age requirement exams as follows:
 - 7 exams in the first year of the child's life;
 - 3 exams in the second year (age 1-2) of the child's life;
 - 3 exams in the third year (age 2-3) of the child's life; and
 - thereafter one exam in a 12-month period through age 18.

For all exams given to your child age 19 and over, covered services will include charges for one exam in a 12-month period.

For you and your spouse or domestic partner:

For all exams given to you or your spouse or domestic partner, covered services will include charges for one exam in a 12-month period.

Routine Cancer Screenings

Covered services include charges incurred for routine cancer screening as follows:

- 1 mammogram per calendar year for covered females age 40 and over;
- 1 baseline mammogram for covered females age 35-39;
- 1 pap smear and related lab fees per calendar year for covered females age 21 and over;

- 1 gynecological exam per calendar year; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test per calendar year for covered males age 40 and older.

The following tests are covered services if you are age 50 - 75 when recommended by your physician:

- 1 fecal occult blood test or stool sample per calendar year; or
- 1 sigmoidoscopy every 5 years for persons at average risk; *or*
- 1 colonoscopy every 10 years for persons at average risk for colorectal cancer.

Additional diagnostic tests may be considered subject to medical necessity.

Charges not covered under this section are:

- services that are covered to any extent under any other part of this Plan or any other group health plan sponsored by RAI or any of its affiliates;
- services that are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a hospital or other place for medical care;
- services not given by a physician or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- immunizations required for occupational hazard or international travel, unless specifically covered by the Plan; or
- premarital exams.

Routine Eye Exam Expenses

Covered services include charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist to a member. Covered services will include charges for one eye exam in a 12-month period.

Charges not covered under this section are:

- any eye exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any services or supplies which are included as covered services under any other benefit section included in this Plan or under any other program of group benefits provided through the Company;
- any services or supplies for which benefits are provided under any Workers' Compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges;
- any service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a hospital or other facility for medical care;
- fitting for contact lenses, glasses or other hardware; or
- any exam required by an employer as a condition of employment, or an employer is required to provide under a labor agreement or is required by any law of a government.

Routine Hearing Exam Expenses

Covered services include charges for one hearing exam in a 12-month period.

Covered services include charges for an audiometric exam. The services must be performed by:

- a physician certified as an otolaryngologist or otologist; or
- an audiologist who either:
 - is legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; or
 - who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Charges not covered under this section are:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other program of group benefits provided through the Company;
- any hearing care service or supply for which a benefit is provided under any Workers' Compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a hospital or other facility for medical care; or
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Skilled Nursing Care Expenses

Skilled nursing care may be a covered service when:

- the services are ordered by a licensed physician (MD or DO) as part of a treatment plan for a covered medical condition, and
- are performed by or under the direct supervision/accountability of a licensed nurse (i.e., an RN or LPN).

To receive skilled nursing services in the home, a member is considered homebound and eligible for home health benefits when the following three criteria are met:

- the patient requires physical assistance and significant supervision by another person in order to leave his/her residence and travel to a physician's office or outpatient treatment facility;
- absences from the home are infrequent or for periods of relatively short duration, and are attributable to the need to receive health care treatments (such as kidney dialysis or outpatient chemotherapy or radiation therapy); and
- a physician has ordered treatments requiring nursing supervision of such frequency or duration that it is unreasonable to expect the patient to receive this supervision in an outpatient facility or a physician's office.

Note: Lack of transportation is not a medical criterion to be considered homebound.

One home nursing visit performed within 72 hours of discharge is eligible for coverage if the mother and newborn are discharged earlier than 48 hours following a normal vaginal delivery or earlier than 96 hours following a Cesarean section delivery. Additional services are subject to medical necessity review.

Charges not covered under this section:

This section does not cover charges made for that part or all of any nursing care that does not require the education, training, and technical skills of an RN or LPN, such as:

- services provided by a family member;
- transportation, meal preparation, charting of vital signs and companionship activities;
- services considered integral to other reimbursed services (e.g., skilled nursing care in the acute inpatient hospital setting);
- services for custodial care; or
- any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an RN or LPN.

Skilled Nursing Facility Expenses

Precertification is required and care is limited to 100 days per calendar year. Covered services include charges made by a skilled nursing facility for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. **These services require prior review and certification or services will not be covered:**

- room and board (includes charges for services, such as general nursing care made in connection with room occupancy);
- use of special treatment rooms;
- x-ray and lab work;
- physical, occupational or speech therapy;
- oxygen and other gas therapy; and
- other medical services usually given by a skilled nursing facility (does not include private or special nursing, or physician's services).

Benefits will be paid for no longer than the number of days shown in the Summary of Coverage charts for any one calendar year.

Charges not covered under this section:

This section does not cover charges made for treatment of:

- drug addiction;
- chronic brain syndrome;
- alcoholism;
- senility;
- mental retardation; or
- any other mental disorder.

Home Health Care Expenses

Home health care expenses may be a covered service if a home health agency coordinates the services your doctor orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home. **Home health care requires prior review and certification or services will not be covered.**

Home health care expenses are charges for:

- part-time or intermittent care by an RN, or by an LPN if an RN is not available;
- part-time or intermittent home health aide services for patient care;
- physical, occupational and speech therapy; and
- the following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
 - medical supplies, drugs and medicines prescribed by a physician; and
 - lab services provided by or for a home health care agency.

Benefits will be paid for no longer than the Home Health Care maximum number of visits in any one calendar year (see Summary of Coverage charts).

Charges not covered under this section:

This section does not cover charges made for:

- dietitian services or meals;
- homemaker services, such as cooking and housekeeping;
- services or supplies that are not a part of the home health care program;
- services of a person who usually lives with you or is a member of your or your spouse's or domestic partner's family;
- services of a social worker;
- transportation;
- services for Infusion Therapy; or
- services that are considered custodial care.

Hospice Care

Covered services include 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.

Charges not covered under this section:

Unless specified above, *not* covered under this benefit are charges for:

- funeral arrangements;
- pastoral counseling;
- financial or legal counseling, including estate planning and the drafting of a will;
- homemaker or caretaker services. These are services which are not solely related to your care, including, but not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house; or
- purchase of durable medical equipment.

Rehabilitative and Habilitative Therapy Expenses

Covered services include charges for therapy services when prescribed by a physician as described below, up to the benefit maximums listed in the Summary of Coverage charts. The services must be performed by:

- a licensed or certified physical, occupational or speech therapist;
- a hospital, skilled nursing facility, or hospice facility;
- a home health care agency; or
- a physician.

Charges for the following short term rehabilitation expenses are covered:

- Cardiac and Pulmonary Rehabilitation Benefits; and
- Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation, and Habilitative Benefits

Coverage is subject to the limits, if any, shown in the Summary of Coverage charts; coverage is also subject to periodic medical necessity review. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits:

- Physical therapy (including spinal manipulation) is covered for certain conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for autistic disorders, non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Please be aware that educational treatment is not covered.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A “visit” consists of no more than one hour of therapy. Refer to the Summary of Coverage charts for the visit maximum that applies to the Plan. Covered services include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- details the treatment, and specifies frequency and duration;
- provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- allows therapy services, provided in your home, if you are homebound.

Charges not covered under this section are:

- visits determined not to be medically necessary based upon the treatment plan submitted by the provider;
- services which are covered to any extent under any other part of this Plan;
- any services which are covered services in whole or in part under any other group health plans sponsored by RAI or any of its affiliates;
- services not performed by a physician or under his direct supervision;
- services rendered by a physical, occupational or speech therapist who resides in the person’s home, or who is a part of the family of either the person or the person’s spouse or domestic partner; or
- group classes for pulmonary rehabilitation.

Also, not covered are any services unless they are provided in accordance with a specific treatment program which:

- details the treatment to be rendered and the frequency and duration of the treatment; and
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Specialized Care

Chemotherapy

Covered services include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, the Plan follows the transplant guidelines.

Radiation Therapy Benefits

Covered services include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes. Some radiation services require prior review and certification of the services will not be covered. Your physician should contact BCBS for additional information.

Outpatient Infusion Therapy Benefits

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Covered services include charges made on an outpatient basis for infusion therapy by:

- a free-standing facility;
- the outpatient department of a hospital; or
- a physician in his/her office or in your home.

Prior review and certification is required for certain home infusion therapy services, or services will not be covered.

Charges for the following outpatient infusion therapy services and supplies are covered services:

- the pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- professional services;
- total parenteral nutrition (TPN);
- chemotherapy;

- drug therapy (includes antibiotic and antivirals);
- pain management (narcotics); and
- hydration therapy (includes fluids, electrolytes and other additives).

Charges not covered under this infusion therapy section are:

- enteral nutrition;
- blood transfusions and blood products;
- dialysis; and
- insulin.

Coverage for inpatient infusion therapy is provided under the “Inpatient Hospital Expenses” and “Skilled Nursing Facility Expenses” sections.

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Obesity Treatment

Non-surgical treatment

Covered services include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- an initial medical history and physical exam;
- nutritional counseling (in accordance with federal preventive care guidelines); and
- diagnostic tests given or ordered during the first exam.

Surgical treatment

Covered services include surgical treatment of morbid obesity. Morbid obesity surgical services require prior review and certification or services will not be covered. Contact BCBSNC Customer Service for the requirements needed to qualify for surgical treatment.

Coinsurance paid by the Plan for a morbid obesity surgical procedure (bariatric surgery) will vary based on the provider used. The Plan pays 80% after deductible for services provided by a Blue Distinction Center for Bariatric Surgery® and 60% for services provided by other Network providers. No coverage is offered out-of-network.

Blue Distinction Centers for Bariatric Surgery®

Blue Distinction Centers for Bariatric Surgery® are selected based on their ability to meet defined clinical quality criteria. We provide enhanced benefits for covered services performed at these designated centers.

Travel Expenses and Lodging Expenses

Only patients who select one of the Blue Distinction Centers for Bariatric Surgery (BDC patient) may be eligible for certain travel and lodging expenses.

Reimbursement for travel and lodging will only be available if the surgery at the Blue Distinction Center requires you to travel 100 miles or two hours from your permanent residence.

The Plan must be primary for the procedure.

All expenses must be approved in advance by BCBSNC. Please contact BCBSNC about the travel and lodging reimbursement including how to submit receipts for expenses.

Travel Expenses

These are expenses incurred by a BDC patient for transportation between his or her home and the Blue Distinction Centers for Bariatric Surgery medical facility to receive services in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion for transportation when traveling with a BDC patient between the BDC patient's home and the Blue Distinction Centers for Bariatric Surgery medical facility to receive such services.

Lodging Expenses

These are expenses incurred by a BDC patient for lodging away from home:

- while traveling between his or her home and the Blue Distinction Centers for Bariatric Surgery medical facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the Blue Distinction Centers for Bariatric Surgery medical facility in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion, and approved in advance by BCBSNC, for lodging away from home:

- while traveling with a BDC patient between the BDC patient's home and the Blue Distinction Centers for Bariatric Surgery medical facility to receive services in connection with any listed procedure or treatment; or
- when the companion's presence is required to enable the BDC patient to receive such services from the Blue Distinction Centers for Bariatric Surgery medical facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the lodging expenses maximum of \$100 per night (\$50 for the BDC patient and \$50 for the companion).

For the purpose of determining travel expenses or lodging expenses, a hospital or other temporary residence from which the BDC patient travels in order to begin a period of treatment at the Blue Distinction Centers for Bariatric Surgery medical facility, or to which he or she travels after dismissal from the Blue Distinction Centers for Bariatric Surgery medical facility at the end of a period of treatment, will be considered to be the BDC patient's home.

Covered items include expenses related to housing, gas and parking only:

- Hotel
- Furnished all-inclusive apartment/ temporary corporate housing
- Gas for travel to the bariatric facility for bariatric surgery related services only
- Airfare
- Parking
- Train fare
- Taxi fare
- Bus fare
- RV rental parks
- Mileage may be reimbursed for the initial evaluation appointments

Non-covered items include:

- Meals
- Food
- Beverages
- Phone calls
- Rental car
- Pet Fees
- Non-furnished apartments requiring separate payment to utility or other service providers
- Reimbursement or credit card charges for housing to family, friends or other individuals
- Medical expenses such as copays and medications
- Personal household expenses
- Travel or lodging expenses incurred by more than one companion per night

Travel and Lodging Benefit Maximum

For all travel expenses and lodging expenses incurred in connection with any one Blue Distinction Centers for Bariatric Surgery Procedure or treatment type:

- the total benefit payable will not exceed the travel and lodging maximum of \$10,000; and
- benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes a BDC patient and ends on the earlier of:

- one year after the day the procedure is performed; and
- the date the BDC patient ceases to receive any services from the Blue Distinction Centers for Bariatric Surgery medical facility in connection with the procedure.

Please Note: To ensure coverage, all bariatric procedures are subject to prior review and certification.

Charges not covered under this obesity section are:

Unless specified above, not covered under this benefit are charges incurred for:

- bariatric surgery services performed at a non-Blue Distinction Centers for Bariatric Surgery, except as noted above;
- removal of excess skin from the abdomen, arms or thighs;
- any costs associated with membership in a weight management program; or
- any services not described above.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered services include charges made by a physician, a dentist and hospital, including oral surgery involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions and are limited to a single \$7,500 lifetime maximum benefit:

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

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

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

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

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

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

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

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

Charges not covered under this section are:

- 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; or
 - periodontal disease or cavities and disease due to infection or tumor.

- and except as specifically stated as covered, treatment such as:
 - dental implants or root canals;
 - orthodontic braces;
 - removal of teeth and intrabony cysts;
 - procedures performed for the preparation of the mouth for dentures; or
 - crowns, bridges, dentures or in-mouth appliances.

TMJ Benefits

Therapeutic benefits for TMJ disease include splinting and use of intra-oral prosthetic appliances to reposition the bones. Surgical benefits for TMJ disease are limited to surgery performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is medically necessary. Please have your provider contact BCBSNC before receiving surgical treatment for TMJ.

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

Charges not covered under this section are:

- treatment for periodontal disease;
- dental implants or root canals;
- crowns and bridges;
- orthodontic braces;
- occlusal (bite) adjustments; or
- extractions.

Plastic and Reconstructive Surgery

Reconstructive breast surgery following and performed as a result of a medically necessary mastectomy is covered. Covered reconstructive breast surgery includes surgery to reestablish symmetry between the two breasts, augmentation mammoplasty, reduction mammoplasty and mastopexy. This includes coverage for breast prostheses and all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive surgery on the diseased breast is performed, and also includes coverage for physical complications in all stages of mastectomy, including lymphadenomas. The length of hospital stay, if any, following a mastectomy shall be determined by the covered individual's attending physician in consultation with the covered individual and shall be based on the unique characteristics of the covered individual, taking into consideration the covered individual's health and medical history.

In all cases other than reconstructive surgery following a medically necessary mastectomy, cosmetic surgery (including breast augmentation and reduction) is not covered unless required to repair:

- serious disfigurement caused by accidental injury (e.g., severe burns);
- birth defect (e.g., congenital anomaly such as cleft lip or cleft palate) in a dependent child; or
- prior medically necessary surgery (e.g., mastectomy).

Durable Medical Equipment and Prosthetic Appliances

Covered services include durable medical equipment and supplies required for operation of equipment when prescribed by a physician. The decision to rent or purchase is at the discretion of BCBSNC. 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.

Please Note:

Foot Orthotics are limited to \$300 per calendar year.

Cranial bands limited to one per lifetime. In-network and out-of-network services are combined for this limitation.

Refer to the Summary of Coverage charts for additional details about durable medical, surgical equipment deductible, and payment percentage located at the end of this document.

Charges not covered under this section are:

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

Also refer to the “Not Covered (Exclusions)” section for information about home and mobility exclusions.

Prosthetic Appliances

The Plan provides benefits for the purchase, fitting, adjustments, repairs, and replacement of prosthetic appliances. The prosthetic device 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.

Charges not covered under this section are:

- dental appliances except when medically necessary for the treatment of temporomandibular joint disease or obstructive sleep apnea;
- cosmetic improvements, such as implantation of hair follicles and skin tone enhancements;
- lenses for keratoconus or any other eye procedure except as specifically covered under the Plan;
- orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace;
- trusses, corsets, and other support items; or
- any item listed in the “Not Covered (Exclusions)” section.

Diabetic Equipment, Supplies and Education

Covered services include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- external insulin pumps;
- blood glucose monitors without special features unless required due to blindness;
- alcohol swabs;
- glucagon emergency kits;
- self-management training provided by a licensed health care provider certified in diabetes self-management training;
- foot care to minimize the risk of infection; and
- insulin and syringes for the treatment of diabetes.

Diagnostic and Pre-Operative Testing

Outpatient Diagnostic Lab Work and Radiological Services

Covered services include charges for radiological services other than diagnostic complex imaging, lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

Prior to a scheduled covered surgery, covered services include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered services and the tests are:

- related to your surgery, and the surgery takes place in a hospital or surgery center;
- performed on an outpatient basis;
- not repeated in or by the hospital or surgery center where the surgery will be performed; and
- test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed.

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

Diagnostic Complex Imaging Expenses

Subject to prior review and certification by your physician, the Plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- Computed Axial Tomography (CAT) scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) scans;
- Nuclear medicine; and
- Cardiac Imaging.

Complex imaging expenses for pre-operative testing will be payable under this benefit. Certain diagnostic imaging procedures, such as CT scans, PET scans and MRIs, may require prior review and certification or services will not be covered.

Family Planning Services

Covered services include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury.

Covered services include charges for family planning services, including voluntary sterilization. Benefits for complications of pregnancy are available to all female members including dependent children.

Basic Infertility Expenses

Covered services include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility. Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of infertility for all members except dependent children. Benefits are limited to a combined in- and out-of-network lifetime maximum per member.

For more information about medical policies on infertility and the lifetime maximum limits, see the BCBS website at www.bcbsnc.com and search for "infertility," or call BCBSNC Customer Service. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations.

Contraception Services

Covered services include charges for contraceptive services and supplies provided on an outpatient basis, including:

- injectable contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration; and
- related outpatient services such as:
 - consultations;
 - exams;
 - procedures; and
 - other medical services and supplies.

Charges not covered under this section are:

- charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by RAI;
- oral contraceptives (see the Prescription Drug SPD for coverage);
- charges incurred for contraceptive services while confined as an inpatient;
- charges for reversal of voluntary sterilization procedures, including related follow-up care;
- items listed in the "Not Covered (Exclusions)" section;
- voluntary termination of pregnancy, unless medically necessary if the life of the mother is in danger;
- intrauterine and intracervical insemination;
- assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, in vitro fertilization (IVF) with fresh or frozen embryos, ovum or embryo

placement, intracytoplasmic sperm injection (ICSI), zygote intrafallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian (GIFT) and associated services;

- treatment for infertility or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause;
- oocyte and sperm donation;
- cryopreservation of oocytes, sperm, or embryos; or
- surrogate mothers.

Acupuncture/Acupressure Therapy

The Plan covers charges made for acupuncture or acupressure services, if the service is performed:

- as a form of anesthesia in connection with a covered surgical procedure; or
- as part of a course of treatment for an illness or injury which is performed in connection with other covered services.

For the purposes of the acupuncture or acupressure services above, a physician will include an acupuncturist certified by the American Association for Acupuncture and Oriental Medicine, who is practicing within the scope of both his certification and the laws of the jurisdiction where the treatment is given.

Acupuncture/acupressure therapy is limited to twenty (20) visits per calendar year.

Ambulance Service

Covered services include charges made by a professional ambulance service, as follows:

Ground Ambulance

Covered services include charges for transportation:

- to the first hospital where treatment is given in a medical emergency;
- from one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- from hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition and determined to be medically necessary;
- from home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition; and
- when during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

Covered services include charges for transportation to a hospital by air or water ambulance when:

- ground ambulance transportation is not available or the pick-up point is not accessible by land;
- your condition is unstable, and requires medical supervision and rapid transport; and
- in a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; *and* the two conditions above are met.

Nonemergency air or water ambulance services require prior review and certification or services will not be covered.

Charges not covered under this section are:

Not covered under this benefit are charges incurred to transport you:

- primarily for the convenience of travel;
- to or from a doctor's office or dialysis center;
- for the purpose of receiving services that are not considered covered services, even if the destination is an appropriate facility;
- if an ambulance service is not required by your physical condition;
- if the type of ambulance service provided is not required for your physical condition; or
- by any form of transportation other than a professional ambulance service.

Clinical Trials

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

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

Charges not covered under this section are:

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

Other Covered Services

Other Covered services include the following when medically necessary:

- anesthetics and oxygen;
- services rendered by a chiropractor when medically appropriate (visits are limited to 20 per calendar year and are subject to periodic review to ensure services are medically appropriate).

Transplants

The Plan provides benefits for transplants, including hospital and professional services for covered transplant procedures. The Plan provides care management for transplant services and will help you find a hospital or Blue Distinction Center for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed up to a \$10,000 maximum per transplant based on BCBSNC guidelines that are available upon request from a transplant coordinator. Benefits may vary depending upon where you receive your transplant.

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body. For a list of covered transplants, call BCBSNC Customer Service to speak with a transplant coordinator and request prior review. Certification must be obtained in advance from BCBSNC for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive surgery are not considered transplants.

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

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

Some transplant services are investigational and are not covered for some or all conditions or illnesses.

Coinurance paid by the Plan for a transplant procedure will vary based on the provider used. The Plan will pay 80% after deductible for services provided by a Blue Distinction Center for Transplants and 60% for services provided by other in-network or out-of-network providers.

Blue Distinction Centers for Transplants.

Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. We provide enhanced benefits for covered transplant services performed at these designated centers.

Travel Expenses and Lodging Expenses

Only patients who select one of the Blue Distinction Centers for Transplants (BDC patient) may be eligible for certain travel and lodging expenses.

Reimbursement for travel and lodging will only be available if the surgery at Blue Distinction Center requires you to travel 100 miles or 2 hours from your permanent residence.

The Plan must be primary for the procedure.

All expenses must be approved in advance by BCBSNC. Please contact BCBSNC about the travel and lodging reimbursement including how to submit receipts for expenses.

Blue Distinction Center Procedure and Treatment Types (examples)

Heart transplant	Heart/lung transplant	Lung transplant
Kidney transplant	Liver transplant	Pancreas transplant
Bone marrow transplant	Kidney/pancreas transplant	Kidney/liver transplant

Travel Expenses

These are expenses incurred by a BDC patient for transportation between his or her home and the Blue Distinction Centers for Transplants medical facility to receive services in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion for transportation when traveling with a BDC patient between the BDC patient's home and the Blue Distinction Centers for Transplants facility to receive such services.

Lodging Expenses

These are expenses incurred by a BDC patient for lodging away from home:

- while traveling between his or her home and the Blue Distinction Centers for Transplants medical facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the Blue Distinction Centers for Transplants facility in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion, and approved in advance by BCBSNC, for lodging away from home:

- while traveling with an BDC patient between the BDC patient's home and the Blue Distinction Centers for Transplants facility to receive services in connection with any listed procedure or treatment; or
- when the companion's presence is required to enable the BDC patient to receive such services from the Blue Distinction Centers for Transplants medical facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the lodging expenses maximum of \$100 per night (\$50 for the BDC patient and \$50 for the companion).

For the purpose of determining travel expenses or lodging expenses, a hospital or other temporary residence from which the BDC patient travels in order to begin a period of treatment at the Blue Distinction Centers for Transplants medical facility, or to which he or she travels after dismissal from the Blue Distinction Centers for Transplants medical facility at the end of a period of treatment, will be considered to be the BDC patient's home.

Covered items include expenses related to housing, gas and parking only:

- Hotel
- Furnished all-inclusive apartment/ temporary corporate housing
- Gas for travel to the transplant facility for transplant related services only
- Airfare
- Parking
- Train fare
- Taxi fare

- Bus fare
- RV rental parks
- Mileage may be reimbursed for the initial evaluation appointments

Non-Covered Items include:

- Meals
- Food
- Beverages
- Phone calls
- Rental car
- Pet fees
- Non-furnished apartments requiring separate payment to utility or other service providers
- Reimbursement or credit card charges for housing to family, friends or other individuals
- Medical expenses such as copays and medications
- Personal household expenses
- Travel or lodging expenses incurred by more than one companion per night

Travel and Lodging Benefit Maximum

For all travel expenses and lodging expenses incurred in connection with any one Blue Distinction Centers for Transplants Procedure or treatment type:

- the total benefit payable will not exceed the travel and lodging maximum of \$10,000; and
- benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes a BDC patient and ends on the earlier of:
 - one year after the day the procedure is performed; and
 - the date the BDC patient ceases to receive any services from the Blue Distinction Centers for Transplants medical facility in connection with the procedure.

Charges not covered under this section:

Travel expenses and lodging expenses do not include and no benefits are payable for any charges which are included as Covered services under any other part of this Plan.

The following are also excluded:

- 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.

Please Note: To ensure coverage, all transplant procedures are subject to prior review and certification or services will not be covered.

Spine Surgery

The Plan offers spine surgery through the Blue Distinction Centers for Spine Surgery. Blue Distinction Centers for Spine Surgery are designated facilities within the Blue Cross and Blue Shield network that demonstrate a commitment to quality care, resulting in better overall outcomes for spine surgery patients. The Plan provides enhanced benefits for covered services performed at these designated centers.

Coinurance paid by the Plan for a spine surgery procedure will vary based on the provider used. The Plan will pay 80% after deductible for services provided by a Blue Distinction Centers for Spine Surgery and 60% for services provided by other in-network or out-of-network providers.

To find out information on BCBSNC's medical policies and your Blue Distinction Centers for Spine Surgery options call BCBSNC Customer Service.

Travel Expenses and Lodging Expenses

Only patients who select one of the Blue Distinction Centers for Spinal Surgery (BDC patient) may be eligible for certain travel and lodging expenses.

Reimbursement for travel and lodging will only be available if the surgery at Blue Distinction Center requires you to travel 100 miles or two hours from your permanent residence.

The Plan must be primary for the procedure.

All expenses must be approved in advance by BCBSNC. Please contact BCBSNC about the travel and lodging reimbursement including how to submit receipts for expenses.

Travel Expenses

These are expenses incurred by a BDC patient for transportation between his or her home and the Blue Distinction Centers for Spinal Surgery medical facility to receive services in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion for transportation when traveling with a BDC patient between the BDC patient's home and the Blue Distinction Centers for Spinal Surgery facility to receive such services.

Lodging Expenses

These are expenses incurred by a BDC patient for lodging away from home:

- while traveling between his or her home and the Blue Distinction Centers for Spinal Surgery medical facility to receive services in connection with any listed procedure or treatment; or
- to receive outpatient services from the Blue Distinction Centers for Spinal Surgery facility in connection with any listed procedure or treatment.

Also included are expenses incurred by a companion, and approved in advance by BCBSNC, for lodging away from home:

- while traveling with an BDC patient between the BDC patient's home and the Blue Distinction Centers for Spinal Surgery facility to receive services in connection with any listed procedure or treatment; or
- when the companion's presence is required to enable the BDC patient to receive such services from the Blue Distinction Centers for Spinal Surgery medical facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the lodging expenses maximum of \$100 per night (\$50 for the BDC patient and \$50 for the companion).

For the purpose of determining travel expenses or lodging expenses, a hospital or other temporary residence from which the BDC patient travels in order to begin a period of treatment at the Blue Distinction Centers for Spinal Surgery medical facility, or to which he or she travels after dismissal from the Blue Distinction Centers for Spinal Surgery medical facility at the end of a period of treatment, will be considered to be the BDC patient's home.

Covered Items include expenses related to housing, gas and parking only:

- Hotel
- Furnished all-inclusive apartment/ temporary corporate housing
- Gas for travel to the surgery facility for surgery related services only
- Airfare
- Parking
- Train fare
- Taxi fare
- Bus fare
- RV rental parks
- Mileage may be reimbursed for the initial evaluation appointments

Non-Covered Items include:

- Meals
- Food
- Beverages
- Phone calls
- Rental car
- Pet fees
- Non-furnished apartments requiring separate payment to utility or other service providers
- Reimbursement or credit card charges for housing to family, friends or other individuals
- Medical expenses such as copays and medications
- Personal household expenses
- Travel or lodging expenses incurred by more than one companion per night

Travel and Lodging Benefit Maximum

For all travel expenses and lodging expenses incurred in connection with any one Blue Distinction Centers for Spinal Surgery procedure or treatment type:

- the total benefit payable will not exceed the Travel and Lodging Maximum of \$10,000; and
- benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes a BDC patient and ends on the earlier of:
 - one year after the day the procedure is performed; and
 - the date the BDC patient ceases to receive any services from the Blue Distinction Centers for Spinal Surgery medical facility in connection with the procedure.

Mental Health/Substance Abuse Benefits

The Plan provides benefits for the treatment of mental disorders and substance abuse by a hospital, doctor, or other behavioral health provider. Certain benefits require prior review (see the “Definitions” section).

Prior review is not required for office visit services, outpatient therapy sessions and treatment, psychological testing, and medication management services.

Prior review is required for the following services:

- inpatient admissions; and
- residential treatment facility admissions.

BCBSNC delegates prior review and administration of inpatient and residential treatment facility admission benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Magellan’s behavioral health medical staff will review treatment needs, provide referrals to high quality practitioners and/or facilities, review treatment with providers to monitor the quality of care and validate the ongoing medical necessity of treatment services provided.

To request prior review, please call Magellan Behavioral Health at 800-359-2422, which is available to you 8 a.m. to 7 p.m. Eastern time Monday through Friday.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider’s office for the treatment of mental disorders as follows:

Inpatient Treatment. Covered services include charges for room and board and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. Prior review is required.

Outpatient Treatment. Covered services include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Covered outpatient services include:

- partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week); and
- intensive therapy services (less than four hours per day and minimum of nine hours per week) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment.

Treatment of Substance Abuse

Covered services include charges made for the treatment of substance abuse by behavioral health providers.

Inpatient Treatment. The Plan covers room and board at, and other services and supplies provided during your stay in, a psychiatric hospital or residential treatment facility appropriately licensed by the state department of health or its equivalent. Prior review is required. Coverage includes:

- treatment in a hospital for the diagnosis and medical complications of substance abuse (“medical complications” include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis).

Outpatient Treatment. Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Covered outpatient services include:

- partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week); and
- intensive therapy services (less than four hours per day and minimum of nine hours per week) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment.

Women's Preventive Services

Since the federal recommendations for women's preventive care may change from time to time, please visit the BCBSNC website at www.bcbsnc.com/preventive or call BCBSNC Customer Service for the most up-to-date information on preventive care that is covered under federal law, including any limitations that may apply.

Well-Woman Visits

Covered services include well-woman preventive care visits and annual routine physicals when performed by an in-network physician.

- Coverage of prenatal visits during pregnancy are limited to pregnancy-related physician office visits (routine).

Items not considered preventive include (but may not be limited to) inpatient admissions, high-risk special visits, ultrasounds, amniocentesis, fetal stress tests, certain pregnancy diagnostic lab tests, and delivery including anesthesia.

Women Health Screenings and Counseling

The following services are covered services when provided as part of any routine annual exam or well-woman exam:

- screening for human papillomavirus (HPV);
- counseling for sexually transmitted infections;
- counseling and screening for human immune-deficiency virus (HIV); and
- screening and counseling for interpersonal and domestic violence.

Women Gestational Diabetes Screening

Screening provided for pregnant women between 24 and 28 weeks of gestation and for pregnant women identified to be at high risk for diabetes.

Five diabetes lab tests that can be taken during pregnancy are included in the list of standard, covered preventive care services.

Women Breastfeeding Support, Supplies and Counseling

Comprehensive lactation (breastfeeding) support and counseling, during pregnancy and/or in the postpartum period, and costs for breastfeeding equipment as described below are covered services when performed by a trained provider:

Breast Pump

- One manual or electric breast pump purchase per delivery is covered.
- Benefit available after member has delivered the baby.
- Breast pumps come with certain supplies, such as tubing, shields, and bottles. All other supplies are excluded (i.e. creams, nursing bras, replacement tubing for breast pump).
- Breast pumps may be purchased from participating Durable Medical Equipment (DME) vendors. Please keep in mind that not all participating DME vendors carry all items. Please check with the participating vendor of choice to see if they carry breast pumps. Edgepark is a vendor that carries breast pumps (1-800-321-0591) or logon to www.bcbsnc.com for a complete list of network providers.
- Hospital grade breast pumps are excluded and not covered.

Lactation Support and Counseling

- Six visits per year to a qualified lactation consultant for either individual or group classes. Any additional visits (7+) are covered according to the Plan's provisions.

Women's Contraceptive Methods and Counseling

Coverage across the full range of FDA-approved contraceptives methods is provided. These include drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.

Administration of Contraceptives

- Associated office visits for the administration of contraceptive devices (i.e. insertion of IUD; injectables) are covered services when performed by an in-network physician. For more information on contraceptive methods covered by the Plan, visit the BCBSNC website or call BCBSNC Customer Service.
- If a medical provider provides the contraceptive device or injectable and bills BCBSNC directly, it is also a covered expense under this section.

Contraceptive Counseling

- Contraceptive counseling is a covered service under this section when performed by an in-network physician.

Female Sterilization

- Female sterilization procedures are covered services under this section when performed by an in-network physician as follows:
 - The sterilization procedures that must be considered preventive include surgical sterilization either abdominally, vaginally or laparoscopically.
 - Eligible charges for a sterilization procedure and all ancillary services will be covered under this section when it is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed separately.
 - Hysterectomies are excluded; anesthesia services will pay at 100% only for sterilization. Sterilization applies to all places of services, with the exception of emergency room. Separately billed services are not covered under preventive services and are subject to the normal benefits based on place of service.

Not Covered (Exclusions)

Not every medical service or supply is covered by the Plan, even if prescribed, recommended, or approved by your physician or dentist. The Plan covers only those services and supplies that are medically necessary, as determined by BCBSNC, and included in the “Covered services” section. Charges made for the following are not covered except to the extent listed under the “Covered services” section. The medical policies referenced in the below exclusions are available by visiting the website www.bcbsnc.com or calling 877-275-9787.

1. Allergy: Services except as described in the BCBSNC medical policy for allergy testing and treatment.
2. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Plan description.
3. The following therapies are excluded:
 - music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly;
 - maintenance therapy; and
 - massage therapy.
4. Services for or related to the transplantation of animal or artificial organs or tissues. See the BCBSNC medical policy for transplants.
5. Blood: Blood stem cells - collection and storage of blood stem cells taken from baby's umbilical cord. Also excluded are 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.
6. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Plan.
7. Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license or by physicians not recognized under the Plan, including: services or treatments by faith healers, psychic surgeons, Christian Science practitioners, hypnotists or other persons who do not meet the definition of a physician.
8. Over-the-counter contraceptive supplies including but not limited to female condoms, contraceptive foams, jellies and ointments unless prescribed by a healthcare provider. Male condoms are excluded.
9. Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons, including but not limited to:
 - face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
 - procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
 - chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
 - insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;
 - removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
 - repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
 - surgery to correct gynecomastia;
 - breast augmentation; and
 - otoplasty.

This exclusion 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.

10. Costs for services resulting from the commission of, or the attempt to commit, a felony by the covered person, unless the services are for an injury that results from an act of domestic violence or a medical condition.
11. Counseling: Marriage, religious, family, career, social adjustment, pastoral, financial counseling, or counseling with a relative about a patient.
12. Court-ordered services, including those required as a condition of parole or release.
13. Custodial care - designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a doctor.
14. Dental services: Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
 - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and application of fluoride and other substances to protect, clean or alter the appearance of teeth;
 - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
 - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
15. Disposable outpatient supplies: Except as covered under the “Durable Medical Equipment” and Diabetic Equipment, Supplies and Education” sections or elsewhere in this Plan description, any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.
16. Drugs, medications and supplies:
 - over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription, including vitamins;
 - any services related to the dispensing, injection or application of a drug;
 - any prescription drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States;
 - immunizations related to work;
 - needles, syringes and other injectable aids, except as covered for diabetic supplies;
 - drugs related to the treatment of non-covered services;
 - performance enhancing steroids;
 - implantable drugs and associated devices;
 - injectable drugs if an alternative oral drug is available;
 - outpatient prescription drugs;
 - self-injectable prescription drugs and medications;
 - any prescription drugs, injectables, or medications or supplies provided by the Plan or through a third party vendor contract with the Plan;
 - Hemophilia prescription drugs; and
 - charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Certain of the drugs, medications and supplies listed above may be covered under the Prescription Drug Plan. Also see the Prescription Drug Benefits section for details about prescription drug coverage under the Plan.
17. Education services/equipment primarily for educational treatment including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the Plan.

18. Examinations: Any health examinations:
- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; or
 - any special medical reports not directly related to treatment except when provided as part of a covered service.
19. Expenses to the extent they are not reasonable charges, as determined by BCBSNC.
20. Experimental services: Services whose efficacy has not been established by controlled clinical trials, or are not recommended as preventive service by the U.S. Public Health Service, except as specifically covered by the Plan.
21. Residential 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.
22. Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for prescription prenatal vitamins or prescription vitamin B-12 injections for anemias, neuropathies or dementias secondary to a vitamin B-12 deficiency, or certain over-the-counter medications that may be available under your preventive care benefits for certain individuals.
23. Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:
- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
 - shoes (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.
24. Growth/height: Any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones.
25. Hearing:
- any hearing service or supply that does not meet professionally accepted standards; and
 - any tests, appliances, and devices for the improvement of hearing, including hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.
26. Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:
- bathroom equipment such as bathtub seats, benches, rails, and lifts;
 - purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
 - exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, massage devices or over-bed tables;
 - equipment or supplies to aid sleeping or sitting, including electric beds, water beds, air beds, pillows, sheets, blankets, warming or cooling devices, elevating chairs, bed tables and reclining chairs;
 - equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;

- other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
 - services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
 - removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
 - transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.
27. Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
28. Home uterine activity monitoring.
29. Infertility: Except as specifically described in the “Covered Services” section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
- drugs related to the treatment of non-covered benefits;
 - injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
 - artificial insemination;
 - any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”) and intra-cytoplasmic sperm injection (“ICSI”);
 - artificial insemination for covered females attempting to become pregnant who are not infertile as defined by the Plan;
 - infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
 - procedures, services and supplies to reverse voluntary sterilization;
 - infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
 - the purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
 - charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
 - home ovulation prediction kits or home pregnancy tests;
 - any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, laboratory tests) and any charges associated with obtaining sperm for any ART procedures; and
 - ovulation induction and intrauterine insemination services if you are not fertile.
30. Late discharge fees except when medically necessary.
31. Miscellaneous charges for services or supplies including:
- annual fees or other charges to be in a physician’s practice;
 - charges to have preferred access to a physician’s services such as boutique or concierge physician practices;
 - cancelled or missed appointment charges or charges to complete claim forms; and
 - charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - care in charitable institutions;
 - care for conditions related to current or previous military service;

- care while in the custody of a governmental authority;
 - any care a public hospital or other facility is required to provide; or
 - any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
32. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
33. Non-medically necessary services, including but not limited to those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by BCBSNC, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
34. Personal comfort and convenience items. Examples include, but are not limited to: any service or supply primarily for your convenience and personal comfort or that of a third party, such as: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, meals, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
35. Private duty nursing during your stay in a hospital; services provided by a close relative or a member of your household; and outpatient private duty nursing services except as specifically described in the *Private Duty Nursing* provision in the “Covered Services” section.
36. Sex changes: Treatment or studies leading to or in connection with sex changes or modifications and related care including any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
- surgical procedures to alter the appearance or function of the body;
 - hormones and hormone therapy;
 - prosthetic appliances; and
 - medical or psychological counseling.
37. Care or services from a provider who:
- Cannot legally provide or legally charge for the services, for example because the 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; or
 - Is not recognized by BCBSNC as an eligible provider.
38. Services provided where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care and cancer screenings.
39. Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
- surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
 - sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
40. Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings; hypnosis and other therapies; medications, nicotine patches and gum other than tobacco cessation counseling sessions that are covered as preventive care.
41. Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continued Group Health Plan Coverage section of this Plan description.
42. Services that are not covered under this Plan description.
43. Services not consistent with the diagnosis for which the patient is being treated.
44. Services and supplies provided in connection with treatment or care that is not covered under the Plan.

45. Speech therapy for treatment of stammering and stuttering including services, supplies, drugs or equipment used for the control or treatment of stammering or stuttering
46. Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the "Covered Services" section.
47. Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
 - exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
 - drugs or preparations to enhance strength, performance, or endurance; and
 - treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations.
48. Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered except as specifically provided in the "Covered Services" section. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
49. Therapies and tests: Including but not limited to any of the following treatments or procedures:
 - aromatherapy;
 - bio-feedback and bioenergetic therapy;
 - carbon dioxide therapy;
 - chelation therapy (except for heavy metal poisoning);
 - computer-aided tomography (CAT) scanning of the entire body;
 - educational therapy;
 - gastric irrigation;
 - hair analysis;
 - hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
 - Lovaas therapy;
 - massage therapy;
 - megavitamin therapy;
 - primal therapy;
 - psychodrama;
 - purging;
 - recreational therapy;
 - rolfing;
 - sensory or auditory integration therapy;
 - sleep therapy;
 - therapy which consists of crafts (basket weaving, ceramics, loom work, bead work, sewing and other similar activities); and
 - thermograms and thermography.
50. Transplant: Transplant coverage does not include charges for:
 - 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; or
 - Services for or related to the transplantation of animal or artificial organs or tissues.
51. Transportation costs, including ambulance services provided primarily for the convenience of travel.

52. Vision-related services and supplies: The Plan does not cover:
- anti-reflective coatings;
 - special supplies such as non-prescription sunglasses and subnormal vision aids;
 - vision service or supply which does not meet professionally accepted standards;
 - tinting of eyeglass lenses;
 - special vision procedures, such as orthoptics, vision therapy or vision training;
 - eye exams during your stay in a hospital or other facility for health care;
 - eye exams for contact lenses or their fitting;
 - eyeglasses or duplicate or spare eyeglasses or lenses or frames;
 - replacement of lenses or frames that are lost or stolen or broken;
 - acuity tests;
 - eye surgery for the correction of vision, including LASIK and similar procedures;
 - services to treat errors of refraction;
 - 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 or the eye’s natural crystalline lens; and
 - Orthoptics, vision training, and low vision aids.
53. Voluntary termination of pregnancy, except when the life of the mother is in danger.
54. Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions (except as provided by this Plan description), including but not limited to:
- liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery unless treating morbid or extreme obesity;
 - surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of, obesity unless treating morbid or extreme obesity;
 - drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
 - counseling, coaching, training, hypnosis or other forms of therapy; and
 - exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
55. Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.
56. Side effects and complications of the non-covered services except for emergency services in the case of an emergency.
57. Ear or body piercing.
58. Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing or as required to be covered as preventive care by the Affordable Care Act.
59. Hypnosis except when used for control of acute or chronic pain.
60. Inpatient admissions primarily for the purpose of receiving diagnostic services or physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except

when the admission is a continuation of treatment following care at a facility for an illness or accident requiring therapy.

61. Claims not submitted to BCBSNC within 24 months of the date charged as incurred, except in the absence of legal capacity of the member.
62. 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.
63. Administrative charges billed by a provider, including charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, and telephone charges.
64. Equipment: Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment, including
 - devices and equipment used for environmental accommodation requiring vehicle and or building modifications such as but not limited to chair lifts, stair lifts, home elevators, and ramps;
 - physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or memberships to health clubs;
 - personal computers; and
 - standing frames.
65. Services that would not be necessary if a non-covered service had not been received, except for emergency services in the case of an emergency. This includes any services, procedures or supplies associated with cosmetic services, investigational services, and services deemed not medically necessary if not specifically covered by the Plan.
66. Respite care, whether in the home or in a facility of inpatient setting, except as specifically covered by the Plan.

Utilization Management

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

Rights and Responsibilities Under the UM Program

Your Member Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable federal time frames;
- The reasons for BCBSNC's adverse benefit determination of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision;
- Have a medical director from BCBSNC make a final determination of all adverse benefit determinations that were based upon medical necessity;
- Request a review of an adverse benefit determination through the appeals process (see "What if You Disagree With a Decision?"); and
- 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. See the "Your Benefit Contact" section;
- 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; and
- Provide you and your provider prompt notification of the UM decision consistent with applicable federal law and the Plan.

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

Prior Review (Pre-Service)

The Plan requires that certain health care services receive prior review and certification. These types of reviews are called "pre-service reviews." The following are examples of services that require pre-service reviews. Your provider should check the BCBS website for the most up-to-date list of services that require prior review and certification.

- Inpatient hospital (for medical and mental health/substance abuse benefits)
- Residential treatment facility for mental health/substance abuse benefits
- Skilled nursing facility
- Home health care
- Private duty nursing care
- Transplants
- Bariatric surgery
- Home sleep studies
- The application of the in-network benefit level to an out-of-network provider, when a member does not have reasonable geographic access to an in-network provider.

See the "Mental Health/Substance Abuse Benefits" section for services related to mental health or substance abuse.

Under the Plan, if:

- a person becomes confined in an out-of-network hospital as a full-time inpatient; and
 - it has not been certified that such confinement (or any day of such confinement) is necessary; and
 - the confinement has not been ordered and prescribed by an in-network provider; then
- a \$200 penalty applies (per occurrence) for failure to obtain a pre-service review of inpatient services. Benefits for all other covered services, in excess of the pre-certification penalty, will be paid at the benefit levels shown in the Summary of Coverage charts.

Under the Out of Area PPO, a \$200 penalty will also apply if you do not pre-certify an inpatient hospital admission.

A \$200 penalty applies (per occurrence) for failure to pre-certify inpatient skilled nursing facility services for both the PPO and Out of Area PPO plans.

Certain services require prior review and certification by the Plan in order to receive benefits. In-network providers in North Carolina will request prior review when necessary. In-network inpatient facilities outside of North Carolina will also request prior review for you, except for Veterans' Affairs (VA) and military providers. If you go to any other provider outside of North Carolina or to an out-of-network provider in North Carolina, you are responsible for ensuring that you or your provider requests prior review by BCBSNC. The Plan delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Failure to request prior review and receive certification may result in allowed charges being reduced or a full denial of benefits.

If prior review is required by the Plan, you or your provider must request prior review regardless of whether this Plan is your primary or secondary coverage (see the “Coordination of Benefits” section). Also, the Plan requires notification for members who have Medicare as their primary coverage and who are admitted to a Medicare-certified hospital or nonhospital facility. If neither you nor your provider requests prior review and receives certification, this may result in an adverse benefit determination.

To request prior review, please call the numbers in the “Your Benefit Contact” section of this SPD.

General categories of services with this requirement are listed above. You may also visit the BCBSNC website at www.mybcbsnc.com or call BCBSNC Customer Service at the number listed in the “Your Benefit Contact” section for a detailed list of these services. The list of services that require prior review may change from time to time.

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

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

Urgent Prior Review

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your life, health, or safety, or the life, health or safety of others, due to your psychological state, or (ii) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to adverse health consequences without the care or treatment that is the subject of the request. BCBSNC will notify you and your provider of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your provider of its decision within 72 hours after receiving the request. Your provider will be notified of the decision, and if the decision results in an adverse benefit determination, written notification will be provided to you and your provider. If BCBSNC needs more information to process your urgent review, BCBSNC will notify you and your provider of the information needed as soon as possible but no later than 24 hours 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 after receipt of requested information or the end of the time period given to the provider to submit necessary clinical information.

An urgent review may be requested by calling BCBSNC Customer Service.

Concurrent Reviews

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

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting hospital or other facility within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request. In the event of an adverse benefit determination, BCBSNC will notify you, your hospital's or other facility's UM department and your provider within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for covered services you are receiving until you or your representatives have been notified of the adverse benefit determination.

Urgent Concurrent Review

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

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

Retrospective Reviews (Post-Service)

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

Care Management

Members with complicated and/or chronic medical needs may 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.

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

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an out-of-network provider or a non-Blue Distinction Center for ongoing special conditions at the in-network benefit level when the member or employer changes plans or when your provider is no longer in the PPO network.

If your PCP or specialist leaves the BCBSNC provider network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the provider's termination, as long as BCBSNC receives timely notification from the provider. To be eligible for continuity of care, the member must be actively being seen by the out-of-network provider for an ongoing special condition and the provider must agree to abide by the BCBSNC requirements for continuity of care.

An ongoing special condition means:

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

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be subject to the in-network benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the provider which are not eligible for additional reimbursement. Continuity of care will not be provided when the provider's contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call BCBSNC Customer Service for more information.

Delegated Utilization Management

BCBSNC delegates UM and the first level appeal for inpatient and residential treatment facility mental health and substance abuse services to Magellan Behavioral Health.

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, BCBSNC offers an appeals process for members.

If you want to appeal an adverse benefit determination, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the member or an authorized representative acting on the member's behalf with the member's written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your provider of the decision. The type of adverse benefit determination will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing within 180 days after an adverse benefit determination or by the date indicated on your Explanation of Benefits.

Any request for review should include:

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

To request a form to submit a request for review, visit the BCBSNC website at www.mybcbsnc.com or call BCBSNC Customer Service at the number given in "Your Benefit Contacts."

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

BCBSNC
Customer Service
P.O. Box 30055
Durham, NC 27702-3055

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

You will have exhausted the Plan's internal appeal process after pursuing a first level appeal. Unless otherwise noted below, upon completion of the first level appeal you may: pursue a second level appeal; pursue an external review; or pursue a civil action under 502(a) of ERISA. You will also be deemed to have exhausted the Plan's internal appeal process at any time it is determined that BCBSNC failed to strictly adhere to all claim determinations and appeal requirements under federal law (other than minor violations). In the event you are deemed to have exhausted the Plan's internal appeal process, and unless otherwise noted below, you may pursue an external review.

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and residential treatment facility mental health and substance abuse services to Magellan Behavioral Health.

Quality of Care Complaints

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

First Level Appeal

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

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

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

Second Level Appeal

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

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

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

Notice of Decision

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

- The specific reason(s) for the denial, including information sufficient to identify the claim; a statement describing the availability of the diagnosis code and treatment codes and their corresponding meanings; the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was used in denying the claim;
- Reference to the Plan provisions on which the decision is based;
- A statement that the member is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the member's claim for benefits;
- If applicable, a statement describing any voluntary appeals procedures and the member's right to receive information about the procedures as well as the member's right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request;
- Instructions on how to request an external, independent review from an independent review organization (IRO) upon completion of this review if not satisfied with the decision (available for non-certifications only);
- The right to pursue other voluntary alternative dispute resolution options as applicable;
- If the decision is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided without charge upon request;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Expedited Appeals (Available only for Non-certifications)

You have the right to a more rapid or expedited review of a non-certification 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 the "Your Benefit Contacts" section. An expedited review will take place in consultation with a medical doctor. All of the same conditions for a first level or second level appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your provider as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

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

External Review

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

- an adverse benefit determination,
- an appeal decision upholding an adverse benefit determination, or
- a final internal adverse benefit determination.

In order to request an external review, BCBSNC must receive your request within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. To request an external appeal, send your request to the following:

BCBSNC
Customer Service
P.O. Box 30055
Durham, NC 27702-3055

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

Within three (3) business days of (or, for an expedited review, after receiving) receiving your request for an external review, the Plan must determine whether the external review is eligible ("preliminary review"). The request is eligible if it meets the following requirements:

- Your request is about a non-certification or a rescission of coverage;
- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- You have exhausted, or have been deemed to have exhausted (as defined above), the Plan's internal appeal process; and
- You provided all the information and forms required to process an external review.

Within one (1) business day of (or, for expedited review, immediately upon) completing the preliminary review, the Plan will notify you in writing of whether your request is complete and whether it has been accepted. If the

Plan notifies you that the request is incomplete, you must provide all requested information to the Plan within the four (4) month filing period or within 48 hours following the receipt of the notice, whichever is later.

If the Plan accepts your request, the assigned IRO will timely notify you in writing of the acceptance of the external review. The notice will include a notification that you may submit additional written information and supporting documentation relevant to the adverse benefit determination to the assigned IRO within seven (7) business days following the date of receipt of the notice. Within five (5) business days (for an expedited review, as expeditiously as possible) after the date of assignment of the IRO, the Plan shall provide the IRO the documents and any information considered in making the adverse benefit determination.

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

The IRO's external review decision is binding on you and the Plan, except to the extent you may have other remedies available under applicable federal law. You may not file a subsequent request for an external review involving the same adverse benefit determination, for which you have already received an external review decision.

Additional Terms of Your Coverage

Benefits to which Members are Entitled

The benefits described in this benefit booklet are provided only for members. These benefits and the right to receive payment under this Plan cannot be transferred or assigned to any other person or entity, including providers. Under the plan, BCBSNC may pay a provider directly. For example, BCBSNC pays in-network providers directly under applicable contracts with those providers. However, any provider's right to be paid directly is through such contract with BCBSNC, and not through the Plan. Under the Plan, BCBSNC has the sole right to determine whether payment for services is made to the provider, to the subscriber, or allocated among both. BCBSNC's decision to pay a provider directly in no way reflects or creates any rights of the provider under the Plan, including but not limited to benefits, payments or procedures.

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

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

Any amounts paid by the Plan for non-covered services or that are in excess of the benefit provided under your PPO or Out of Area PPO coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a member's future claims payments. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if BCBSNC pays the provider amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

Amounts paid by the Plan for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the member, the employer or the workers' compensation insurer (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.

Administrative Discretion

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

North Carolina Provider Reimbursement

BCBSNC has contracts with certain providers of health care services for the provision of, and payment for, health care services provided to all members entitled to health care benefits. BCBSNC's payment to providers may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the provider. Under certain circumstances, a contracting provider may receive payments from BCBSNC greater than the charges for services provided to an eligible member, or BCBSNC may pay less than charges for services, due to negotiated contracts. The member is not entitled to receive any portion of the payments made under the terms of contracts with providers. The member's liability when defined as a percent of charge shall be calculated based on the lesser of the allowed amount or the provider's billed charge for covered services provided to a member.

Some out-of-network providers have other agreements with BCBSNC that affect their reimbursement for covered services provided to PPO 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 PPO allowed amount and the contracted amount. Out-of-network providers may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

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

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

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

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

This "negotiated price" can be:

- A simple discount that reflects the actual price paid by the Host Blue to your provider,
- An estimated price that factors in special arrangements with your provider or with a group of providers that may include types of settlements, incentive payments, and/or other credits or charges, or
- An average price, based on a discount that reflects the expected average savings for similar types of health care providers after taking into account the same types of special arrangements as with an estimated price.

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

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

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

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

Right of Recovery Provision

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

In addition, if a member receives any payment from any potentially responsible party as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the member for all amounts the Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the member receives from all potentially responsible parties. The member agrees that if the member receives any payment from any potentially responsible party as a result of an injury or illness, the member will serve as a constructive trustee over the funds which must be held in a constructive trust 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 first priority equitable lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a member receives from the third party, the third party's insurer or any other source as a result of the member's injuries. The lien is in the amount of benefits paid by the Plan for the treatment of the illness, injury or condition for which another party is responsible.

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

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 potentially responsible party payments, even if such payment to the Plan will result in a recovery to the member which is insufficient to make the member whole or to compensate the member in part or in whole for the damages sustained. It is further understood that the Plan 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 after 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.

If the Plan makes overpayments or payments in error, the Plan Administrator, at its sole discretion, has the right to recover the payments or overpayments from anyone who received or benefited from them. If the Plan made payments based on fraudulent information you provided, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered.

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 24 months after the member incurs the covered service, except in the absence of legal capacity of the member. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the member or the member's authorized representative within 30 days of receipt of a notice of claim if the member has financial liability on the claim other than a copayment or other services where payment was made at the point of service (unless the Plan has chosen to provide an explanation of benefits for additional claims where the member does not have a financial liability other than a copayment).

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

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

- The specific reason(s) for the denial of benefits, including information sufficient to identify the claim;
- A statement describing the availability of the diagnosis code and treatment codes and their corresponding meanings; the denial code and its corresponding meaning, as well as the Plan's standard, if any, that was used in denying the claim;
- Reference to the Plan provision on which the denial of benefits is based;
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
- A description of the review procedures and the time limits applicable to such procedures, including the member's right to bring a civil action under Section 502(a) of ERISA following a denial of benefits;

- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request;
- If the denial of benefits is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the member's medical circumstances, or a statement that this will be provided without charge upon request;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman; and
- In the case of a denial of benefits involving urgent care, a description of the expedited review process available to such claims.

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

Limitation of Actions

No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the appeals process. You must only exhaust the first level appeal process following the Notice of Claim requirement.

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

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

Coordination of Benefits

If a member is also enrolled in another group health plan, the Plan may take into account benefits paid by the other plan. These coordination of benefits rules apply to any plan that provides medical or dental care coverage:

- by any group insurance, or by any other method of coverage for persons in a group,
- by any hospital, medical or dental service organization, group practice, individual practice, HMO, or other group prepayment arrangement,
- by any governmental plan, including Medicare Title XVIII of the Federal Social Security Act as it now is, or may be changed, and
- required by law (a person subject to law who has not complied with the law will be deemed to have received the benefits required by the law).

To the extent that medical services are covered by a no fault motor vehicle plan, the Plan does not pay benefits. A "no fault motor vehicle plan" is a motor vehicle plan which is required by law and provides medical or dental care payments which are made, in whole or in part, without regard to fault.

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.

When you claim benefits under this Plan, you're required to inform BCBSNC of any information necessary to administer these COB provisions. Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. Payment by BCBSNC under the Plan takes into account whether or not the provider is a participating provider. If the Plan is the secondary plan, and the member uses a participating provider, the Plan will coordinate up to the allowed amount. The participating provider has agreed to accept the allowed amount as payment in full.

If you receive services from an out-of-network provider, you are responsible for any charges not paid by either group insurance plan. You may wish to check with the primary group insurance plan to find out if an out-of-network provider participates in the primary group insurance plan's network and whether this affects your responsibility for paying up to the provider's charges.

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

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

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

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a dependent is		√
The person is covered as a dependent child under both plans and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the dependent child's health care coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the dependent child's health care coverage	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	<i>Note: When the parents have the same birthday, the plan that covered the parent longer is</i>	√	
The person is covered as a dependent child under both plans and parents are divorced/separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree*; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.		
The person is covered as a dependent child under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	<i>Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's plan are</i>	√	
The person is covered as a laid-off or retired member or that member's dependent on one of the plans, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired member or as that member's dependent is	√	
	The plan that covers a person as a laid-off or retired member or the dependent of a laid-off or retired member is		√
	Note: This rule does not apply if it results in a conflict with any of the other rules for 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	√	
	The plan that has been in effect the shorter amount of time is		√

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

Definitions

These definitions will help you understand the Plan.

ADVERSE BENEFIT DETERMINATION

A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational (and is not otherwise covered under the "Clinical Trial" benefit) or not medically necessary or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

ALLOWED AMOUNT

(See the "Medical Plan Terms You Need to Know" section for the definition.)

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; and
- d. Is not other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other provider.

ANCILLARY PROVIDER

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

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

BENEFIT PERIOD

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

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

(See the "Medical Plan Terms You Need to Know" section for the definition.)

COMPLICATIONS OF PREGNANCY

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

CONGENITAL

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

COSMETIC

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

COVERED SERVICE(S)

(See the "Covered Services" section for the definition and details.)

DEDUCTIBLE

(See the "Medical Plan Terms You Need to Know" section for the definition.)

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 covered under the Plan, 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.

DOCTOR or PHYSICIAN

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. Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, low vision aids and telephone alert systems.

EDUCATIONAL TREATMENT

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

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.

ERISA

The Employee Retirement Income Security Act of 1974.

EXPERIMENTAL

(See the definition of "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.

HABILITATIVE SERVICES

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

HOMEBOUND

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

HOME HEALTH AGENCY

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

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

HOSPICE

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

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

HOSPITAL

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

IDENTIFICATION CARD (ID CARD)

The card issued to members upon enrollment which provides employer/member identification numbers, names of the members, and key benefit information, phone numbers and addresses.

INCURRED

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

INFERTILITY

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

IN-NETWORK

Designated as participating in the PPO network. BCBSNC's payment for in-network covered services is described in this SPD 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 PPO provider by BCBSNC or a provider participating in the BlueCard program. Ancillary

providers outside North Carolina are considered in-network only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard program.

INVESTIGATIONAL (EXPERIMENTAL)

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

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

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

LICENSED PRACTICAL NURSE (LPN)

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

LIFETIME MAXIMUM

The benefit maximum of certain covered services that will be reimbursed on behalf of a member while covered under the Plan. Services in excess of any lifetime maximum are not covered services, and members may be responsible for the entire amount of the provider's billed charge. See the "Summary of Coverage" chart and "Covered Services" section for any limits that may apply.

MEDICAL SUPPLIES

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY)

Those covered services or supplies that are, as determined by BCSCNC:

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

MEMBER

An employee or dependent who satisfies the requirements in the "Eligibility" section of the Overview of Health Plans, who is currently enrolled in the Plan and for whom premium is paid.

MENTAL ILLNESS

When applied to an adult member, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a dependent child, a mental condition, other than mental retardation alone, that so impairs the dependent child's capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-V"). Mental illness does not include substance-related disorders, Sexual Dysfunctions, and disorders coded as "V" codes in the DSM-V (including, without limitation, learning disabilities and Autism).

NON-CERTIFICATION

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

NONHOSPITAL FACILITY

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

OFFICE VISIT

Medical care, surgery, diagnostic services, rehabilitative and habilitative therapy services and medical supplies provided in a provider's office.

OTHER PROFESSIONAL PROVIDER

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

OTHER PROVIDER

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

OTHER THERAPY(IES)

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

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

OUT-OF-NETWORK

Not designated as participating in the PPO network, and not certified in advance by BCBSNC to be considered as in-network. Payment for out-of-network covered services is described in this SPD as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER

A provider that has not been designated as a PPO provider by BCBSNC.

OUT-OF-POCKET LIMIT

(See the "Medical Plan Terms You Need to Know" section for the definition.)

OUTPATIENT CLINIC

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

POSITIONAL PLAGIOCEPHALY

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

PRESCRIPTION

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

PREVENTIVE CARE

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

PRIMARY CARE PROVIDER (PCP)

An in-network provider who has been designated by BCBSNC as a PCP.

PRIOR REVIEW

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

PROSTHETIC APPLIANCES

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

PROVIDER

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

REGISTERED NURSE (RN)

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

REHABILITATIVE THERAPY

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. Cognitive therapy—treatment associated with physical rehabilitation when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- b. 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.
- c. Physical therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part.
- d. Speech therapy—treatment for the restoration of speech impaired by disease, surgery, or injury; certain significant physical congenital conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

RESIDENTIAL TREATMENT FACILITY

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

RESPITE CARE

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

ROUTINE FOOT CARE

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

SEXUAL DYSFUNCTION

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

SKILLED NURSING FACILITY

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

SPECIALIST

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

STABILIZE

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

SUBSTANCE ABUSE

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your insured dependents.)

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, and
- c. Other procedures as reasonable and approved by BCBSNC.

URGENT CARE

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

UTILIZATION MANAGEMENT (UM)

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

Continuation of the Plan

Although it is the Plan Sponsor's current intention to continue the Medical Plan, the Plan Sponsor reserves the right to terminate the Omnibus Plan or any of the plans included in the Omnibus Plan, including the Medical Plan. The Plan Sponsor also reserves the right to amend, modify or suspend the provisions, terms and conditions of any of the plans in the Omnibus Plan. Termination or modification may be done at any time and without prior notice. Benefits for claims incurred after the effective date of a modification or termination are payable in accordance with the revised Omnibus Plan documents.

The Plan Sponsor has authorized the RAI Employee Benefits Committee to make changes to the Omnibus Plan. The RAI Employee Benefits Committee is authorized to act on behalf of the Plan Sponsor by a resolution approved by a majority of its members. The RAI Employee Benefits Committee may delegate authority to make certain plan modifications to the Benefits Administration Committee.

All statements in this description and all representations by the Plan Sponsor and its personnel are subject to the Plan Sponsor's rights of termination and amendment. These rights apply without limitation, even after an individual's circumstances have changed by retirement or otherwise. All reserves or rebates under any portion of the plan, regardless of origination, which are classified as a "plan asset" under ERISA will be used by the Plan Sponsor, in its sole discretion, for the purpose of providing benefits under the plan (or any successor thereto), for the purpose of paying plan administrative expenses, and/or for any other purpose deemed permissible under ERISA, including, without limitation, reducing funding deficits under other portions of the Omnibus Plan.

Additional Medical Plan Information

Please refer to the Overview of Health Plans for information on Cost, Elections, Change in Family Status, Eligibility, Right of Recovery, General Administration, Your ERISA Rights and Plan Administration.

For information about continuing your benefits if coverage ends, please refer to the General Notice of Continuation Coverage Rights Under COBRA.